**IMPLANT REFERRAL FORM**

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| --- | --- | --- | --- | --- |
| **PATIENT DETAILS** | | | | |
| Patients Title and Name | Age of patient in years | | Sex | Date of Birth (DD/MM/YY) |
| Patient Address | | | | |
| Mobile Telephone Number | Home Telephone Number | | E-mail address | |
| **REFERRAL INFORMATION** | | | | |
| Referring Dentist Name | Referring Dental Practice  Crewe | | Date of decision to refer | |
| GDC Number of referring dentist | Does patient require sedation? Yes No | | | |
| **RADIOGRAPHS** | | | | |
| I can confirm diagnostically acceptable radiographs have been sent with this referral  Bitewings Periapical OPG None (reason required)  Reason if no radiographs........................................................................................................................................... | | | | |
| **TREATMENT REQUESTED** | | | | |
| Reason for referral  Implant assessment advice Implant problems and diagnosis  Implant surgical placement only Augmentation and surgical placement  ToothImplant surgical placement and restoration Other  Brief description of treatment required:  ...........................................................................................  ..........................................................................................  .........................................................................................  .........................................................................................  .........................................................................................  ......................................................................................... | | | | |
| **ADDITIONAL INFORMATION** | | | | |
| Relevant medical information, ie medication including dosages, allergies etc | | | Is the patient a smoker?  Yes No | |
| **PATIENT CONSENT TO REFERRAL** | | | | |
| Has the patient understood and consented to the referral?  Yes No | |  | | |
| **CONFIRMATION AND SIGNATURE OF REFERRING DENTAL PRACTITIONER** | | | | |
| Print Full Name..............................................................................................  Signature...................................................................................................... | | | Date.......................................... | |

Please send all referrals to the following address:

Site Lead

Referral Centre

Alchemy Dental Practice

203 Edleston Road

Crewe

Cheshire

CW2 7HT

Alternatively, referral forms can be emailed using the email address: [info@alchemydental.co.uk](mailto:info@alchemydental.co.uk) with ‘FAO of Site Lead’ in Subject line.