

Dental Implants Referral Form

Date.....

Patient details

Name:..... Sex: M / F

DOB :

Address:

.....

Postcode:

Telephone – Home Mobile

Reason for referral

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History of presenting complaint

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Medical history – including medications and allergies

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Provisional Diagnosis – and any treatment carried out already. Please enclose current radiographs.

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Other relevant information

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.....

GDP Details

Name (Caps)

Signature

Practice address:

.....
..... Post code

Practice tel. no:

Do you wish to restore the fixtures? Yes / No