Implant Referral Form

School of Implant Dentistry

ICE Postgraduate Dental Institute & Hospital

Patient

Name:
……

Date of Birth:
……..

Address:
……
……

Tel Number: ……..

Mobile Number: ……

Email: ……

Referring Practitioner

Name:
……

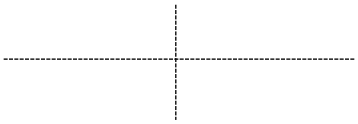
Practice Address:
……
……

Tel Number:
……

Practice Email:
……

Proposed Treatment Details

RMH:
……

Teeth: 

Please provide further details: (e.g. when tooth was XLA, Root Fracture etc) ……
……
……
……
……

The patient is aware that the treatment will be carried out by supervised clinicians training in Implant Dentistry:

☐ YES ☐ NO

Date
……

Please attach any relevant X-rays, if they are available.