

## Implant Referral Form

Referring Dentist \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_ Postcode \_\_\_\_\_

Telephone No. \_\_\_\_\_

Patient's Name \_\_\_\_\_ D.O.B. \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_ Postcode \_\_\_\_\_

Telephone No. (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

(Mobile) \_\_\_\_\_

The patient is experiencing:

- Failed bridgework       Unsightly spaces       Loose dentures  
 Difficulty chewing       Periodontal problems       Failing post crown

Please add relevant medical history \_\_\_\_\_

Please add any other information that you think may be helpful \_\_\_\_\_

My initial treatment plan is \_\_\_\_\_

- I would like to arrange a joint treatment plan for this patient  
 I would like to do the restorative work on the implant(s)

Please return this form to:



York Dental Implant Centre  
96, The Mount, York, YO24 1AR  
Telephone: (01904) 623436  
Email: info@yorkdentalimplantcentre.co.uk  
www.yorkdentalimplantcentre.co.uk