avalon
oral care centre - enhancing your natural smile

Avalon Dental and Implant Centre
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implant referral form

Patient Details

Patient's Name:..... Date of Birth: .....
Patient's Address:..... Home Telephone: .....
..... Work Telephone: .....
..... Mobile: .....
..... E mail: .....

Relevant Medical History

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.....

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Reason for Referral

- ❑ Opinion only
- ❑ Single tooth missing
- ❑ Totally edentulous jaw(s)
- ❑ Multiple teeth missing
- ❑ Full mouth rehabilitation
- ❑ Upper
- ❑ Lower
- ❑ Both

Types of implant retained restoration which have been explained to the patient

- ❑ Single tooth implant
- ❑ Implant & tooth retained bridge
- ❑ Partial overdenture
- ❑ Full restorative case including perio, prostho & implants
- ❑ Implant supported bridge
- ❑ Hybrid prosthesis
- ❑ Full overdenture

Investigations (please tick as appropriate)

❑ OPG ❑ PA's ❑ Other Radiographs ❑ Are these enclosed? ❑ _____

Has the patient been informed of the cost of the consultation/treatment? ❑ Yes ❑ No

Referring Dentist

Referring Dentist: ..... Date Referred: .....
Practice Address:..... Telephone: .....
..... Fax: .....
..... E mail:.....

Thank you for your referral