



S O L I H U L L
DENTAL IMPLANT CENTRE

EXPERT DENTISTRY WITH EXCEPTIONAL DEVOTION

Department of Oral and Maxillo-Facial Surgery
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IMPLANT REFERRAL FORM

practice details

Referring Practice:

Date Referred:

Referring Dentist:

patient details

Patient's name:

Email:

Patient's address:

Telephone numbers: Home:

Work:

Mobile:

Date of Birth:

Is this referral urgent?:

Yes

No

reason for referral (please cross all relevant boxes)

Placement of Implant(s) only

Failing Implants

Placement of Implant(s) and restoration(s)

Combined Care / Mentoring

Totally edentulous jaw(s)

Other

Bone &/or Soft tissue grafting

Details of Case

Single tooth missing

Failing Dentition

Multiple teeth missing

Other

Edentulous jaw(s)

Has the patient been made aware of the level of investment that may be required yes no

brief history / comments about this referral

investigations (please cross all relevant boxes)

OPG

PA's

Other Radiographs

Are these enclosed?

Has the patient been informed of the cost of the consultation/treatment?

Yes

No

Has the patient been informed of the location of Solihull Dental Implant Centre?

Yes

No

We require additional referral forms