|  |  |
| --- | --- |
| Name of Patient |  |
| Date of Birth |  |
| Smoker yes/no | If smokes, please give details |
| Oral Hygiene state | Good  Poor |
| Periodontal Status  (There is no restriction on referring patients with previous history of periodontal disease, but all basic dental treatment needs should have been completed) |  |
| Attends hygiene appointments 3/12\*, 6/12\* | \*Delete as appropriate |
| Further dental treatment planned  (e.g. Extractions, dentures) |  |
| Reason for referral.   * Implant/crown * Bridge * Full arch/stabilisation of denture * Other   N.B PATIENTS REQUIRING MAINTENANCE/MODIFICATION OF EXISTING IMPLANTS PLACED ELSEWHERE SHOULD NOT BE REFFERRED | Please give details: |
| Options discussed with patient  (SHOULD INCLUDE NEW DENTURE, TYPE OF BRIDGE, ETC. IF ONLY WANTS TREATMENT OTHER THAN IMPLANTS PLEASE DO NOT REFER) | Please give details: |
| Patient is aware that they are having a consultation for an implant. | Please confirm: |
| Patient has a recent OPG (after most recent extractions) |  |
| Patient is aware that a 3D scan MAY BE NEEDED.  There will be an additional cost of £100 at an independent provider. |  |
| Patient has been given an estimate of cost of implants | Please detail estimate of costs given to patient |
| Information booklet given |  |



**IMPLANT REFERRAL FORM**