SMILE CARE
PART OF DARWENSIDE DENTAL

IMPLANT REFERRAL FORM

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	