REFERRAL FORM

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HOLMES DENTAL CARE

Patient details

Name: ..... Email: .....

Date of Birth: ..... Home Telephone: .....

Address: ..... Work Telephone: .....

Postcode: ..... Mobile Telephone: .....

Dentist details

Name: ..... Postcode: .....

Practice Address: ..... Telephone: .....

..... Email: .....

Reason for referral

Consultation ☐

Implant(s) placement: ☐

Bone augmentation: ☐

Sinus augmentation (tap/lift): ☐

Orthodontic: ☐

Cosmetic/Restorative dentistry: ☐

Oral Surgery: ☐

Enclosures

Peri-apical ☐

OPT ☐

CBCT scan ☐

Photographs ☐

Other (study models, STL files, DICOM files) ☐

DATE OF REFERRAL ...../...../.....

Patient's main complaint/concern: .....

Brief clinical description of problem: .....

.....

Medical history: .....

.....

Do you wish to restore the implant(s)? ☐ ☐

Are you happy for restorative treatment in adjacent teeth to be completed? ☐ ☐

Any preference for type of retention for the prosthesis? Screw-retained ☐ Cement-retained ☐

In brief, please describe the nature of the problem _____

OFFICE USE ONLY

Referral received on ..... Patient contacted by: Tel ☐ Mob ☐ Email ☐

Enclosures/attachments received Yes ☐ No ☐ Dentist notified: Yes ☐ No ☐

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