My New Smile Altrincham

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Implant / restorative referral form

Practice Details

Referring Practice: Date Referred:

Referring Dentist:

Patient Details

☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Other Patient's Name:

Patient's Address:

Telephone Numbers: Home: Work: Mobile:

Email:

Date of Birth: Is this referral urgent? ☐ Yes ☐ No

Reason for Referral (please cross all relevant boxes)

- ☐ Asessment/Advice/Treatment planning only
- ☐ Implant surgery and associated restorative treatment
- ☐ Other restorative treatment
- ☐ Single unit
- ☐ Multiple units
- ☐ Overdentures
- ☐ Mixed - surgical/restorative/prosthodontics

Restorative Care (please cross all relevant boxes)

- ☐ Aesthetics
- ☐ Routine care under sedation
- ☐ Occulsal Problem
- ☐ Toothware
- ☐ Other (please give details below)

IV conscious sedation is available. Does your patient require sedation? ☐ Yes ☐ No

Investigations (already carried out)

☐ OPG ☐ PA's ☐ Other Radiographs ☐ Are these enclosed? ☐ CT Scan ☐ Are these enclosed?

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

Has the patient been informed on the location of MNS Referral Centre ☐ Yes ☐ No

Would you like to be present at the consultation / surgery? ☐ Yes ☐ No

Dental / Medical History

Thank you for your valued referral