REFERRAL FORM

ANGEL DENTAL IMPLANT CENTRE

☐ **ANGEL DENTAL IMPLANT CENTRE**
BRENT
92 Chamberlayne Road Brent
London NW10 3JL
020 8969 3560
info@angel-implants-centre.co.uk

☐ **ANGEL DENTAL IMPLANT CENTRE**
WESTMINSTER
Unit 4 Monck Street Westminster
London SW1P 2BQ
0204 525 9995
info@angel-implants-centre.co.uk

REFERRING PRACTICE DETAILS

DENTIST NAME

PRACTICE ADDRESS

POSTCODE

PRACTICE PHONE NUMBER

PRACTICE EMAIL ADDRESS

PATIENT CONTACT DETAILS

PATIENT NAME

DATE OF BIRTH

PATIENT ADDRESS

POSTCODE

PATIENT PHONE NUMBER

PATIENT EMAIL ADDRESS

URGENCY

☐ Urgent ☐ Not urgent

REASON FOR REFERRING

☐ Opinion only ☐ Diagnosis and planning ☐ Complete treatment

RELEVANT MEDICAL HISTORY

Continued overleaf

REFERRAL INFORMATION

- ☐ Full mouth rehabilitation: ☐ All-On-Four ☐ All-On-X
- ☐ Zygomatic implants
- ☐ Pterygoid implants
- ☐ EZgoma
- ☐ Nasalis implants
- ☐ Other types of implants
- ☐ Repairing or fixing implants done abroad
- ☐ Nerve repositioning
- ☐ Sinus lift
- ☐ Sinus graft
- ☐ Bone augmentation
- ☐ Intravenous sedation
- ☐ Surgical extraction
- ☐ Surgical exposure
- ☐ Wisdom tooth extraction
- ☐ Apicectomy
- ☐ Dental phobia
- ☐ Sleep apnea
- ☐ Referring DDS to treat prosthetics
- ☐ Orthodontic treatment/Invisalign
- ☐ Prosthodontic treatment
- ☐ Cosmetic treatment
- ☐ Periodontal treatment
- ☐ Facial aesthetics
- ☐ TMJ treatment
- ☐ Stem cell therapy/PRGF
- ☐ Frenectomy surgery
- ☐ CBCT scan
- ☐ OPG
- ☐ Other requirements

Please add any relevant information here

TYPES OF IMPLANTS RESTRAINED RESTORATION

☐ Single tooth implant ☐ Overdenture ☐ Immediate load required ☐ Implant supported bridge

Other requirements

Has the patient been made aware of the level of investment that may be required?

☐ Yes ☐ No

Affected areas

☐ Upper ☐ Lower ☐ Both

ADDITIONAL INFORMATION

Brief history (comments about this referral)

DENTAL X-RAYS ATTACHED

In order to minimise exposure please indicate which radiographs you are sending with the referral:

☐ OPG ☐ PA's ☐ Other Radiographs

The patient will be referred back to your care on completion of implant treatment

SIGNATURE *DATE*