BROAD STREET
DENTAL SURGERY

IMPLANT REFERRAL FORM

Referring practitioners' details	
Practitioners name & GDC number	
Practitioners address	
Practitioners email	
Date of referral	
Patient Details	
Full name	
Date of Birth	
Address	
Contact Number	
Email address	
Relevant Medical History	
Social history including smoking status	
Patient complaint/wishes	
I, the patient agree to be referred to Broad Street Dental Surgery for the assessment of possible dental implants/ as requested by my dentist and I have the reasons for the referral explained to me.	Signed…… Date……

Please provide a short summary of the treatment to be requested. Including :

- Placement of implants only
- Placement of implant/s with complete restoration

Radiographs	Attached	Emailed	With patient	None
CBCT Scan	With Patient	Emailed	To be arranged	None

Please confirm that the patient has optimal oral hygiene and is aware of the need to maintain their oral hygiene for the provision and maintenance of dental implants prior to referral.

Signed…… Date: ……

Please complete this form and return by post or email to **practicemanager@broadstreetdentalsurgery.com**