# IMPLANT REFERRAL FORM

Salisbury Implant Centre

*Committed to Excellence*

## REFERRING DENTIST DETAILS

Date

Full Name :

E-mail:

Telephone:

Address :

## PATIENT DETAILS

Patient's Name:

Date of Birth:

Patient's Address:

Home Tel:

Mobile Tel:

E-mail:

## DENTAL HISTORY

Periodontal Condition:

Oral Hygiene:

Smoking , If yes then how many a day and since how long :

## MEDICAL HISTORY

Anticoagulants:

Allergies:

## REASON FOR REFERRAL

Please note that, if extractions are required, it is recommended to delay this until after the consultation appointment unless symptomatic.

**Radiographs enclosed? Y / N**

**Signed:**

**Date:**

Please complete the form and send to us by post or by email.

**Thank you for your referral**

Email: info@salisburyimplantcentre.co.uk OR Post to :
Salisbury Implant Centre, 151, Fisherton Street , Salisbury SP27RP
We endeavour to respond within 48 hours of receiving referral.