IMPLANTS REFERRAL

PEMBROKE
DENTAL AND IMPLANT CENTRE

Patient Information

Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐

Surname: Forename: DOB:

Address:

Postcode:

Tel (primary): Tel (other): Email:

Tooth requiring treatment:

Reason for referral:

☐ Consultation ☐ Single implant ☐ Multiple Implants ☐ Implant Placement Only

Clinical Situation

☐ Failing Endodontics ☐ Failing Crown and Bridge ☐ Root Fracture ☐ Unrestorable tooth

Treatment required (please specify in as much detail as possible)

Referred by

Name: Practice address:

Postcode:

Signature: Date:

Radiography's included? ☐ Yes ☐ No ☐ Periapical

Bitewings: ☐ Left ☐ Right

Please note that no treatment will be carried out without the express permission of the referring general practitioner

Other (please state):

Relevant Medical History (including medications):

Once you have completed this form please submit it to Pembroke Dental. The contents of this form will be treated in strict confidence

For administrative use only

Data received: Received by:

Action taken:

Clinician: Date:

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