



**WOODSDENTAL**  
SPECIALIST DENTAL SERVICES

## REFERRAL FORM

### REFERRING DENTIST'S DETAILS

Name:

Practice:

Address:

Tel:

Email:

### PATIENT DETAILS

Name:

Date of Birth:

Address:

Tel:  Mob:

Email:

### TEETH / AREAS TO BE TREATED

8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
8	7	6	5	4	4	2	1	1	2	3	4	5	6	7	8

### IMPLANT REFERRALS

#### LEVEL OF REFERRAL

- 1. Assessment and treatment plan only
- 2. Implant Placement and Refer Back for Restoration
- 3. Bone Graft/Sinus Lift and Refer Back to Clinician
- 4. Implant Assessment, Placement and Restoration

#### TREATMENT REQUIRED/DISCUSSED

- 1. Single Implant Supported Crown
- 2. Implant Supported Bridgework
- 3. Implant Supported Denture
- 4. Full Multidisciplinary Restorative Case

### ORAL SURGERY REFERRALS & ENCLOSURES

Extraction required prior to implant? Yes  No  If No, how long since extracted?

#### ORAL SURGERY REFERRALS

- 1. Routine Extraction
- 2. Surgical Extraction
- 3. Impacted Wisdom Teeth
- 4. Apicectomy
- 5. Soft Tissue Surgery/Graft
- 6. Other

#### ENCLOSURES

- 1. Radiographs
- 2. CBCT
- 3. Study Models



 **RELEVANT DENTAL HISTORY**

[Empty area for relevant dental history]

 **RELEVANT MEDICAL HISTORY**

[Empty area for relevant medical history]

Would you like to attend for surgery with your patient? Yes  No

Signature of Referring Dentist:

Date:

**WE THANK YOU FOR YOUR REFERRAL**

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