Garden City IMPLANT & DENTAL
Creating smiles with a smile

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# REFERRAL FORM

## PATIENT DETAILS

Name _____ Dob _____

Address _____ Email _____

Phone _____ Mobile _____

Med Hx _____

Referred For (*please* ☑)

## IMPLANTOLOGY

- ☐ Biohorizons
- ☐ Dentium
- ☐ Ankylos
- ☐ Nobel Biocare
- ☐ Other
- ☐ Teeth (Sites) _____
- ☐ Extraction with view to Implant (Non-Traumatic &/Or Socket Grafting)
- ☐ Bone Augmentation/Sinus Elevation may be required
- ☐ Soft Tissue (Gingival or Connective Tissue) Grafting may be required
- ☐ Full Arch Implant Reconstruction
- ☐ Immediate "All On Four" Reconstruction
- ☐ Denture Stabilisation With Implants
- ☐ Return Pt For Restorative Phase - Will a surgical stent be provided Y/N
- ☐ Complete Surgical & Restorative Phase
- ☐ Immediate Implant Restoration or Temporisation Preferred
- ☐ By Surgeon ☐ By referring Dentist

## ORAL SURGERY

- ☐ Wisdom Teeth Management
- ☐ Tooth/Root Removal
- ☐ Frenectomy
- ☐ Crown Lengthening
- ☐ Pre Prosthetic Surgery
- ☐ Tooth Exposure
- ☐ Other

## RADIOGRAPHS ENCLOSED

☐ PA ☐ OPG ☐ CBVI ☐ CT ☐ DICOM DISC

## DETAILS/COMMENTS

_____

_____

_____

Signature _____

## REFERRING DENTIST

Practice _____

Phone _____

Email _____

Date _____

**Suite 15, Upper Level, Gateway Bldg, Andrea Lane,**
**Adjacent to Garden City Shopping Centre, Booragoon WA 6154**
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Dental Practice ACCREDITED