

Date _____

SANDOWN DENTAL & IMPLANT CLINIC ACCEPTS REFERRALS FROM OTHER DENTISTS AND DENTAL PRACTICES. TO MAKE A REFERRAL PRINT THIS PDF AND SEND IT BACK TO US.

Please be assured we will neither approach nor accept your patient for non-referred treatment.

Practice details	
Referring Dentist	
Referring Practice Address	
Tel	
Email	

Patient details	
Name	
Address	
Date of birth	
Telephone	
Mobile	
Email	
Is this referral urgent	

Reasons for referral

- Full mouth reconstruction
- Implant assessment, placement & restoration
- Implant placement & refer back for restoration
- Opinion only
- Single tooth missing
- Multiple teeth missing
- Totally edentulous jaw(s)

Is your request for implant placement only?

Yes No

Types of implant retained restoration which have been explained to the patient

- Single tooth implant
- Partial overdenture
- Full restorative case including perio & implants
- Implant supported bridge
- Full overdenture

Has the patient been made aware of the level of investment that may be required?

Yes No

History

Diagnostic aids

OPG PA's CBCT scan Other radiographs



SANDOWN
DENTAL & IMPLANT CLINIC

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