HOLMES DENTAL CARE

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REFERRAL FORM

Patient Details

Name: Date of Birth:

Address:

Postcode:

Tel No: Home: Work: Mobile:

Email:

Is this referral urgent? Yes ☐ No ☐ Has the patient been referred before? Yes ☐ No ☐

Dentist Details

Name:

Practice Address:

Postcode:

Telephone Number: Email:

Postcode

DATE OF REFERRAL:

Reason for Referral

- ☐ Implant Consultation
- ☐ Implant(s) Placement
- ☐ Bone Augmentation
- ☐ Implant Treatment Planning
- ☐ Sinus Augmentation (tap/lift)
- ☐ Restorative & Aesthetic Dentistry
- ☐ Orthodontic
- ☐ Oral Surgery
- ☐ OPG/CBCT Scan

Clinical Details / Clinical Problem

Relevant Medical History

Do you wish to restore the implant(s)? Yes ☐ No ☐ N/A ☐

Any preference for type of retention for the prosthesis? Screw-retained ☐ Cement-retained ☐ N/A ☐

Enclosures

Yes ☐ **No** ☐ **By email to info@holmesdentalcare.co.uk Yes** ☐ **No** ☐

- ☐ Peri-apical
- ☐ OPT
- ☐ CBCT scan
- ☐ Photographs
- ☐ Other
  (study models, STL files, DICOM files)

The patient will only be treated for the item of treatment that they've been referred for. All patients who have been referred to the practice will be returned back to you once treatment has been completed (unless otherwise requested). It is our policy to keep you informed at the beginning and end of treatment.

Thank you for your referral

OFFICE USE ONLY

Referral received on_____ Enclosures/attachments received Yes ☐ No ☐

Patient contacted by Tel ☐ Mob ☐ Email ☐ Dentist notified Yes ☐ No ☐