



Lyme Bay Dentistry

Implant Referral Form

Practitioner Details

Referring Practitioner:..... Date:.....
Address:.....
.....
Phone:.....Fax:.....
e-mail:.....

Patient Details

Patient Name:.....D.O.B:.....
Contact Address:.....
.....
Contact Phone Nos: Home:.....Work:.....Mobile:.....
e-mail:.....

Patient's main complaint/Dentist's reason for referral

.....
.....
.....

Do you wish to be present at:

- 1) Treatment Planning? YES / NO
 - 2) Placement of fixtures? YES / NO
 - 3) Do you wish to complete the Prosthetics? YES / NO
- If YES, would you like the patient restored to A) Healing Abutments YES / NO
B) Temporary Crowns YES / NO

Medical History

Relevant Medical details:.....
.....
.....
Current Medication.....

Clinical Details

Radiographs enclosed? OPG Y/N PAs Y/N
Others.....
Further details: (e.g. special requests by patient or referring practitioner)
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Please Fax to 01297 442255
Or Post to Lyme Bay Dentistry
Temple House, 63 Broad Street
Lyme Regis, Dorset, DT7 3QF