The Village Dental Practice
General Dentistry - Oral Surgery - Implantology - Sedation

Oral Surgery/ Implant Referral Form

Patient's name		**Mr /Mrs /Miss /Ms /Mst / Other:**	
Date of birth			
Full Address			
Daytime phone number		**Mobile number**	
Name of referring dentist:		**Practice Name / Address:**	
Telephone number			

Date of referral	
Tooth (teeth) requiring treatment	**8 7 6 5 4 3 2 1 / 1 2 3 4 5 6 7 8** **8 7 6 5 4 3 2 1 / 1 2 3 4 5 6 7 8**

Reason for referral

☐ Dental implant ☐ Pre-Prosthetic surgery ☐ Treatment of patients taking bisphosphonates ☐ Sedation might be required	☐ Surgical extraction of teeth ☐ Apicectomy ☐ Extraction of teeth following failed extraction ☐ Other Dental Treatments under Sedation

Symptoms	
Requested procedure	

Relevant patient dental history	
Relevant patient medical history	

Radiograph(s) attached. **Please staple to the back of this form.**	**Number**	**Date Taken**

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