West Suffolk Oral Surgery and Implant Centre.

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Referral form for Oral & Implant Surgery

Patient Details:

First Name:	Surname:	Mr / Mrs / Miss / Ms	Date of Birth:
Address:			Post Code:
Tel No: (Home)	(Work)		(Mobile)

Referral for Oral Surgery:

Extraction	☐	Apicectomy	☐	Tooth Exposure	☐
Soft Tissue Surgery	☐	Crown Lengthening	☐	Sedation	☐

Referral for Implant Surgery:

Patient would like an initial consultation ☐ Patient would like work-up ☐

Implant surgery to

Regeneration surgery	☐	Bone grafting	☐	Sinus grafting	☐
Guide tissue regeneration	☐	Referring practitioner to carry out restorative treatment			☐

Presenting problem / Patient's History / Observations:

Medical History:

Smoker: Y / N

Referral From:

Address:

Signature: Date:

ALL PATIENTS REMAIN REGISTERED WITH THE REFERRING PRACTICE.