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IMPLANT CENTRE

Specialist Treatment Referral Form

Referring Dentist Details

First Name .....

Surname .....

Practice address .....

.....

Postcode ..... Email .....

Phone ..... Mobile phone .....

Patient Details

First Name ..... DOB .....

Surname .....

Home address .....

.....

Postcode ..... Email .....

Phone ..... Mobile phone .....

Referral for

◯ Opinion ◯ Implant replacments only

◯ Grafting only ◯ Complete treatment

Reason for referral/patient's complaint .....

.....

X-ray to be returned? ◯ Yes ◯ No

Teeth, please tick

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

PTO

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CONTINUED

How would like to be notified of the referral patient's progress?

◯ Email ◯ Post ◯ Phone

Our Referral form

At the end of the specified treatment, we will return your patients back to you for the their continued dental care. We have a strict policy of not taking on any patient who has been referred to us by another practice.

We will keep you informed at the beginning and the end of the treatment. If the patient has only been referred for assessment planning, a letter will be sent back to you as soon as possible.

Please feel free to contact the practice at any time if you have any questions or queries or if you would like to discuss any aspect of the treatment

Signature of referring dentist ..... Date .....

Please scan and email completed form to hello@tendental.com
or post to Ten Dental, 10 The Pavement, London, SW4 OHY.
You can also use our online referral form in the Dentist Area at
www.tendental.com. For further assistance, call us on 0207622 7610.