IMPLANT REFERRAL FORM

Kee Dental Care
confidence in your smile

Kee Dental Care
117 Glanmor Road
Sketty
Swansea
SA2 0RN
01792 298831

hello@keedentalcare.co.uk

PATIENT DETAILS

Name: . . . . . E-mail: . . . . .

Date of Birth: . . . . . Home Telephone: . . . . .

Address: . . . . . Work Telephone: . . . . .

Postcode: . . . . . Mobile Telephone: . . . . .

DENTIST DETAILS

Name: . . . . . Telephone: . . . . .

Practice address: . . . . . E-mai: . . . . .

. . . . . Dentist Signature: . . . . .

Postcode . . . . . Date . . . . .

REASON FOR REFERRAL

Consultation: ☐

Implant(s) placement: ☐

Bone grafting/ soft tissue grafting: ☐

Oral Surgery: ☐

Sedation: ☐

ENCLOSURES

Peri-apical ☐

OPT ☐

CT scan ☐

Photographs ☐

Other (please specify) ☐

DATE OF REFERRAL . . . . . / . . . . . / . . . . .

Preferred Implantologist: No Preference ☐ Dr Darren Owakee ☐ Dr Barry Holmes ☐

Patient's main complaint/ concern: . . . . .

. . . . .

Medical History . . . . .

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

If 'Yes', what type of retention is preferred for the prosthesis? Screw-retained ☐ Cement-retained ☐

straumann ANKYLOS | DENTSPLY IMPLANTS ITI International Team for Implantology