MACARTHUR SURGICAL CENTRE ORAL + MAXILLOFACIAL SPECIALIST

Implant Referral Form

Date of referral *

Day Month Year

Priority *

Please Select

Patient Information

Name *

Prefix First Name Last Name

Phone number *

Email

Patient's existing and pre-existing risk factors *

- ☐ Gum disease
- ☐ Risk of osteonecrosis
- ☐ Prolia injection
- ☐ Received or currently under a radiation therapy
- ☐ Taking anticoagulant medication

- [ ] Reaction to anaesthetic
- [ ] Dementia
- [ ] Anxious patient
- [ ] Other

For Consultation and Care Regarding

Our procedures *

- [ ] Dental implant/s (please specify the site/s on the clinical notes below)
- [ ] Extraction & immediate implantation
- [ ] Extraction & socket preservation
- [ ] All-on-4
- [ ] Management of complication
- [ ] Full-arch implant or All-on-X
- [ ] Sinus lift
- [ ] Bone grafting, ridge or site development
- [ ] Implant removal
- [ ] Other

Does the patient need bone grafting? *

Please Select

Preferred implant system *

- ◯ Straumann
- ◯ Astra-Tech EV (Dentsply)
- ◯ Leave choice to the surgeon

Was there a specific practitioner you are referring to? *

Please Select

Clinical notes to our specialist *

Supporting radiography record *

Please Select

Referring Doctor Information

Name *

Prefix First Name Last Name

Clinic or practice name *

Provider number *

Address *

Street Address

Suburb State

Postcode

Contact number *

Best email correspondence *

Tags

- [ ] Todo
- [ ] In Progress
- [ ] Done