

ARDAN IMPLANT CLINIC

Implant referral form

42 Ashvale Road, Belfast BT9 6QT | 028 9649 6188 | referrals@ardanimplants.co.uk

Referring dentist _____ GDC no. _____

Practice _____

Practice phone _____ Email _____

Patient initials _____ Date of birth ____ / ____ / ____

Referring for: ☐ Single implant ☐ Multiple / bridge ☐ Full arch

☐ Bone graft or sinus lift ☐ Failing implant ☐ Opinion only

Will you be doing the restorative work? ☐ Yes ☐ No ☐ Discuss

Notes _____

Please do not send patient identifiable clinical records with this form.

We will contact you to set up a secure channel.

Concept document. Ardan Implant Clinic is a fictional practice created for portfolio purposes.