Implant Referral Pack

Brighton Implant Centre – **Referral Form**

1 Referring Practitioner:

Date of referral

Title (Dr / Mr / Mrs / Miss / Ms or other)

Name

Practice name

Practice address

Postcode

Tel no Email

2 Patient details:

Title (Dr / Mr / Mrs / Miss / Ms or other)

Date of birth Day Month Year

Name

Address

Postcode

Tel nos Email

3 Summary of case:

4 Level of Referral:

- ☐ Opinion only
- ☐ Augmentation only
- ☐ Surgical placement
- ☐ Full case referral

5 Level of involvement:

- ☐ Initial consultation and treatment planning
- ☐ Surgical aspect
- ☐ Restorative aspect
- ☐ I do not wish to be involved

Any other details:

Enclosures:

Radiographs Photographs study models

Please **fax** this form to 01273 738638 or
post to Dr. Barry Tibbott, Brighton Implant Centre, 14 Brunswick Place, Hove, East Sussex BN3 1NA

Brighton Implant Centre
Dr. Barry Tibbott BDS (LOND) MSC (IMPLANTOLOGY) LDS RCS
14 Brunswick Place, Hove, East Sussex BN3 1NA
Tel 01273 779156 **Fax** 01273 738638
email info@brightonimplantcentre.co.uk
www.brightonimplantcentre.co.uk