Referral letter for implant treatment

Broxtowe Lane Dental Clinic
398 Broxtowe Lane, Nottingham, Nottinghamshire, NG8 5ND

E: reception.nottingham@colosseumdental.co.uk

01159 292264

colosseumdental.co.uk

Referring Dentist Details

Dentist name	
GDC No.	
Dentist email	
Practice name and address	
Practice Tel.	
Practice email	

Patient Details

Name	
DOB	
Address	
Home Tel.	
Mobile Tel.	
Email	
Notes	

Referral for implant treatment

Please read and tick the boxes

☐ I am the Dentist/Hygienist
☐ I am referring the patient for the reasons outlined below

Dentist/Hygienist signature	
Date	

Please note that patients are expected to pay either in advance or on the day, prior to seeing the dentist.

X-rays to be sent to reception.nottingham@colosseumdental.co.uk

Would you like us to provide?

☐ Second Opinion	☐ Treatment

Reasons for referral

We will take a full medical history and ask the patient to sign consent forms prior to an examination/treatment. The referring dentist can request a copy of these documents.

Referral letter for implant treatment

Cambourne Dental Clinic
Monkfield House, Monkfield Lane,
Cambourne, Cambridgeshire,
CB23 6AJ

E. reception.cambourne@colosseumdental.co.uk
01954 718585

colosseumdental.co.uk

Referring Dentist Details

Dentist name	
GDC No.	
Dentist email	
Practice name and address	
Practice Tel.	
Practice email	

Patient Details

Name	
DOB	
Address	
Home Tel.	
Mobile Tel.	
Email	
Notes	

Referral for implant treatment

Please read and tick the boxes

- ☐ I am the Dentist/Hygienist
- ☐ I am referring the patient for the reasons outlined below

Dentist/Hygienist signature	
Date	

Please note that patients are expected to pay either in advance or on the day, prior to seeing the dentist.

X-rays to be sent to reception.cambourne@colosseumdental.co.uk

Would you like us to provide?

☐ Second Opinion ☐ Treatment

Reasons for referral

We will take a full medical history and ask the patient to sign consent forms prior to an examination/treatment. The referring dentist can request a copy of these documents.

Referral letter for implant treatment

Church Hill Dental Clinic
Church Hill, Midhurst,
West Sussex, GU29 9NX

E: reception.churchhill@colosseumdental.co.uk

01730 810010

colosseumdental.co.uk

Referring Dentist Details

Dentist name	
GDC No.	
Dentist email	
Practice name and address	
Practice Tel.	
Practice email	

Patient Details

Name	
DOB	
Address	
Home Tel.	
Mobile Tel.	
Email	
Notes	

Referral for implant treatment

Please read and tick the boxes

☐ I am the Dentist/Hygienist
☐ I am referring the patient for the reasons outlined below

Dentist/Hygienist signature	
Date	

Please note that patients are expected to pay either in advance or on the day, prior to seeing the dentist.

X-rays to be sent to reception.churchhill@colosseumdental.co.uk

Would you like us to provide?

☐ Second Opinion	☐ Treatment

Reasons for referral

We will take a full medical history and ask the patient to sign consent forms prior to an examination/treatment. The referring dentist can request a copy of these documents.

Referral letter for implant treatment

Diplomat House Dental Clinic
Oakfield Street, Blandford Forum,
Dorset, DT11 7EX

E: reception.diplomathouse@colosseumdental.co.uk

01258 456901

colosseumdental.co.uk

Referring Dentist Details

Dentist name	
GDC No.	
Dentist email	
Practice name and address	
Practice Tel.	
Practice email	

Patient Details

Name	
DOB	
Address	
Home Tel.	
Mobile Tel.	
Email	
Notes	

Referral for implant treatment

Please read and tick the boxes

☐ I am the Dentist/Hygienist
☐ I am referring the patient for the reasons outlined below

Dentist/Hygienist signature	
Date	

Please note that patients are expected to pay either in advance or on the day, prior to seeing the dentist.

X-rays to be sent to reception.diplomathouse@colosseumdental.co.uk

Would you like us to provide?

☐ Second Opinion ☐ Treatment

Reasons for referral

We will take a full medical history and ask the patient to sign consent forms prior to an examination/treatment. The referring dentist can request a copy of these documents.

Referral letter for implant treatment

Gravesend Dental Clinic
43 The Grove, Gravesend, Kent, DA12 1DP

E: reception.gravesend@colosseumdental.co.uk

01474 333367

colosseumdental.co.uk

Referring Dentist Details

Dentist name	
GDC No.	
Dentist email	
Practice name and address	
Practice Tel.	
Practice email	

Patient Details

Name	
DOB	
Address	
Home Tel.	
Mobile Tel.	
Email	
Notes	

Referral for implant treatment

Please read and tick the boxes

☐ I am the Dentist/Hygienist
☐ I am referring the patient for the reasons outlined below

Dentist/Hygienist signature	
Date	

Please note that patients are expected to pay either in advance or on the day, prior to seeing the dentist.

X-rays to be sent to reception.gravesend@colosseumdental.co.uk

Would you like us to provide?

☐ Second Opinion	☐ Treatment

Reasons for referral

We will take a full medical history and ask the patient to sign consent forms prior to an examination/treatment. The referring dentist can request a copy of these documents.

Referral letter for implant treatment

Great Knightleys Dental Clinic
188 Great Knightley's, Basildon,
Essex, SS15 5HG

E: reception.greatknightley@colosseumdental.co.uk

01268 541966

colosseumdental.co.uk

Referring Dentist Details

Dentist name	
GDC No.	
Dentist email	
Practice name and address	
Practice Tel.	
Practice email	

Patient Details

Name	
DOB	
Address	
Home Tel.	
Mobile Tel.	
Email	
Notes	

Referral for implant treatment

Please read and tick the boxes ☐ I am the Dentist/Hygienist ☐ I am referring the patient for the reasons outlined below	
Dentist/Hygienist signature	
Date	
Please note that patients are expected to pay either in advance or on the day, prior to seeing the dentist.	
X-rays to be sent to reception.greatknightley@colosseumdental.co.uk	
Would you like us to provide?	
☐ Second Opinion	☐ Treatment
Reasons for referral	

We will take a full medical history and ask the patient to sign consent forms prior to an examination/treatment. The referring dentist can request a copy of these documents.

Referral letter for implant treatment

Highview Dental Clinic
170 Byron Way, Northolt, Middlesex, UB5 6BW

E: reception.highview@colosseumdental.co.uk

02088 413555

colosseumdental.co.uk

Referring Dentist Details

Dentist name	
GDC No.	
Dentist email	
Practice name and address	
Practice Tel.	
Practice email	

Patient Details

Name	
DOB	
Address	
Home Tel.	
Mobile Tel.	
Email	
Notes	

Referral for implant treatment

Please read and tick the boxes

- ☐ I am the Dentist/Hygienist
- ☐ I am referring the patient for the reasons outlined below

Dentist/Hygienist signature	
Date	

Please note that patients are expected to pay either in advance or on the day, prior to seeing the dentist.

X-rays to be sent to reception.highview@colosseumdental.co.uk

Would you like us to provide?

☐ Second Opinion	☐ Treatment

Reasons for referral

We will take a full medical history and ask the patient to sign consent forms prior to an examination/treatment. The referring dentist can request a copy of these documents.

Referral letter for implant treatment

Maidstone Dental Clinic
524 Loose Road, Maidstone,
Kent, ME15 9UF

E: reception.maidstone@colosseumdental.co.uk

01622 743371

colosseumdental.co.uk

Referring Dentist Details

Dentist name	
GDC No.	
Dentist email	
Practice name and address	
Practice Tel.	
Practice email	

Patient Details

Name	
DOB	
Address	
Home Tel.	
Mobile Tel.	
Email	
Notes	

Referral for implant treatment

Please read and tick the boxes ☐ I am the Dentist/Hygienist ☐ I am referring the patient for the reasons outlined below	
Dentist/Hygienist signature	
Date	
Please note that patients are expected to pay either in advance or on the day, prior to seeing the dentist.	
X-rays to be sent to reception.maidstone@colosseumdental.co.uk	
Would you like us to provide?	
☐ Second Opinion	☐ Treatment
Reasons for referral	

We will take a full medical history and ask the patient to sign consent forms prior to an examination/treatment.
The referring dentist can request a copy of these documents.

Referral letter for implant treatment

Mawsley Dental Clinic
Mawsley Dental Clinic, Medical Centre, School Road, Kettering, Northamptonshire, NN14 1SN

E: reception.mawsley@colosseumdental.co.uk
01536 799210

colosseumdental.co.uk

Referring Dentist Details

Dentist name	
GDC No.	
Dentist email	
Practice name and address	
Practice Tel.	
Practice email	

Patient Details

Name	
DOB	
Address	
Home Tel.	
Mobile Tel.	
Email	
Notes	

Referral for implant treatment

Please read and tick the boxes

☐ I am the Dentist/Hygienist
☐ I am referring the patient for the reasons outlined below

Dentist/Hygienist signature	
Date	

Please note that patients are expected to pay either in advance or on the day, prior to seeing the dentist.

X-rays to be sent to reception.mawsley@colosseumdental.co.uk

Would you like us to provide?

☐ Second Opinion ☐ Treatment

Reasons for referral

We will take a full medical history and ask the patient to sign consent forms prior to an examination/treatment. The referring dentist can request a copy of these documents.

Referral letter for implant treatment

Northgate Dental Clinic
1 Wolborough Road, Northgate,
Crawley, West Sussex, RH10 8EZ

E: reception.northgate@colosseumdental.co.uk

01293 543421

colosseumdental.co.uk

Referring Dentist Details

Dentist name	
GDC No.	
Dentist email	
Practice name and address	
Practice Tel.	
Practice email	

Patient Details

Name	
DOB	
Address	
Home Tel.	
Mobile Tel.	
Email	
Notes	

Referral for implant treatment

Please read and tick the boxes

☐ I am the Dentist/Hygienist
☐ I am referring the patient for the reasons outlined below

Dentist/Hygienist signature	
Date	

Please note that patients are expected to pay either in advance or on the day, prior to seeing the dentist.

X-rays to be sent to reception.northgate@colosseumdental.co.uk

Would you like us to provide?

☐ Second Opinion	☐ Treatment

Reasons for referral

We will take a full medical history and ask the patient to sign consent forms prior to an examination/treatment. The referring dentist can request a copy of these documents.

Referral letter for implant treatment

Norwood Dental Clinic
222 Norwood Road,
Norwood, London, SE27 9AW

E: recepton.norwood@colosseumdental.co.uk

02087 6677430

colosseumdental.co.uk

Referring Dentist Details

Dentist name	
GDC No.	
Dentist email	
Practice name and address	
Practice Tel.	
Practice email	

Patient Details

Name	
DOB	
Address	
Home Tel.	
Mobile Tel.	
Email	
Notes	

Referral for implant treatment

Please read and tick the boxes

☐ I am the Dentist/Hygienist
☐ I am referring the patient for the reasons outlined below

Dentist/Hygienist signature	
Date	

Please note that patients are expected to pay either in advance or on the day, prior to seeing the dentist.

X-rays to be sent to recepton.norwood@colosseumdental.co.uk

Would you like us to provide?

☐ Second Opinion ☐ Treatment

Reasons for referral

We will take a full medical history and ask the patient to sign consent forms prior to an examination/treatment. The referring dentist can request a copy of these documents.

Referral letter for implant treatment

Portland Road Dental Clinic
137 Portland Road, Hove,
East Sussex, BN3 5QJ

E: reception.portland@colosseumdental.co.uk

01273 734185

colosseumdental.co.uk

Referring Dentist Details

Dentist name	
GDC No.	
Dentist email	
Practice name and address	
Practice Tel.	
Practice email	

Patient Details

Name	
DOB	
Address	
Home Tel.	
Mobile Tel.	
Email	
Notes	

Referral for implant treatment

Please read and tick the boxes

- ☐ I am the Dentist/Hygienist
- ☐ I am referring the patient for the reasons outlined below

Dentist/Hygienist signature	
Date	

Please note that patients are expected to pay either in advance or on the day, prior to seeing the dentist.

X-rays to be sent to reception.portland@colosseumdental.co.uk

Would you like us to provide?

☐ Second Opinion ☐ Treatment

Reasons for referral

We will take a full medical history and ask the patient to sign consent forms prior to an examination/treatment. The referring dentist can request a copy of these documents.

Referral letter for implant treatment

Stoke Newington
169 Church Street, Stoke Newington, London, N16 OUL

E: reception.stokenewington@colosseumdental.co.uk

02072 546503

colosseumdental.co.uk

Referring Dentist Details

Dentist name	
GDC No.	
Dentist email	
Practice name and address	
Practice Tel.	
Practice email	

Patient Details

Name	
DOB	
Address	
Home Tel.	
Mobile Tel.	
Email	
Notes	

Referral for implant treatment

Please read and tick the boxes

- ☐ I am the Dentist/Hygienist
- ☐ I am referring the patient for the reasons outlined below

Dentist/Hygienist signature	
Date	

Please note that patients are expected to pay either in advance or on the day, prior to seeing the dentist.

X-rays to be sent to reception.stokenewington@colosseumdental.co.uk

Would you like us to provide?

☐ Second Opinion	☐ Treatment

Reasons for referral

We will take a full medical history and ask the patient to sign consent forms prior to an examination/treatment. The referring dentist can request a copy of these documents.

Referral letter for implant treatment

Stone Cross Dental Clinic
1 Mimram Road, Stone Cross,
Pevensey, East Sussex, BN24 5DZ

E: reception.stonecross@colosseumdental.co.uk

01323 769069

colosseumdental.co.uk

Referring Dentist Details

Dentist name	
GDC No.	
Dentist email	
Practice name and address	
Practice Tel.	
Practice email	

Patient Details

Name	
DOB	
Address	
Home Tel.	
Mobile Tel.	
Email	
Notes	

Referral for implant treatment

Please read and tick the boxes ☐ I am the Dentist/Hygienist ☐ I am referring the patient for the reasons outlined below	
Dentist/Hygienist signature	
Date	
Please note that patients are expected to pay either in advance or on the day, prior to seeing the dentist.	
X-rays to be sent to reception.stonecross@colosseumdental.co.uk	
Would you like us to provide?	
☐ Second Opinion	☐ Treatment
Reasons for referral	

We will take a full medical history and ask the patient to sign consent forms prior to an examination/treatment.
The referring dentist can request a copy of these documents.

Referral letter for implant treatment

Triangle Dental Clinic
4 The Triangle, Kingston-Upon-Thames, Surrey, KT1 3RU

E: reception.triangle@colosseumdental.co.uk

02082 960464

colosseumdental.co.uk

Referring Dentist Details

Dentist name	
GDC No.	
Dentist email	
Practice name and address	
Practice Tel.	
Practice email	

Patient Details

Name	
DOB	
Address	
Home Tel.	
Mobile Tel.	
Email	
Notes	

Referral for implant treatment

Please read and tick the boxes

- ☐ I am the Dentist/Hygienist
- ☐ I am referring the patient for the reasons outlined below

Dentist/Hygienist signature	
Date	

Please note that patients are expected to pay either in advance or on the day, prior to seeing the dentist.

X-rays to be sent to reception.triangle@colosseumdental.co.uk

Would you like us to provide?

☐ Second Opinion	☐ Treatment

Reasons for referral

We will take a full medical history and ask the patient to sign consent forms prior to an examination/treatment. The referring dentist can request a copy of these documents.

Referral letter for implant treatment

Welldene Dental Clinic
25 Canterbury Road,
Ashford, Kent, TN24 8JY

E: reception.welldene@colosseumdental.co.uk

01233 624816

colosseumdental.co.uk

Referring Dentist Details

Dentist name	
GDC No.	
Dentist email	
Practice name and address	
Practice Tel.	
Practice email	

Patient Details

Name	
DOB	
Address	
Home Tel.	
Mobile Tel.	
Email	
Notes	

Referral for implant treatment

Please read and tick the boxes

- ☐ I am the Dentist/Hygienist
- ☐ I am referring the patient for the reasons outlined below

Dentist/Hygienist signature	
Date	

Please note that patients are expected to pay either in advance or on the day, prior to seeing the dentist.

X-rays to be sent to reception.welldene@colosseumdental.co.uk

Would you like us to provide?

☐ Second Opinion	☐ Treatment

Reasons for referral

We will take a full medical history and ask the patient to sign consent forms prior to an examination/treatment. The referring dentist can request a copy of these documents.

Referral letter for implant treatment

Westpole Dental Clinic
3 Westpole Avenue, Cockfosters,
Barnett, Hertfordshire, EN4 0AX

E: reception.westpole@colosseumdental.co.uk

02084 419142

colosseumdental.co.uk

Referring Dentist Details

Dentist name	
GDC No.	
Dentist email	
Practice name and address	
Practice Tel.	
Practice email	

Patient Details

Name	
DOB	
Address	
Home Tel.	
Mobile Tel.	
Email	
Notes	

Referral for implant treatment

Please read and tick the boxes

- ☐ I am the Dentist/Hygienist
- ☐ I am referring the patient for the reasons outlined below

Dentist/Hygienist signature	
Date	

Please note that patients are expected to pay either in advance or on the day, prior to seeing the dentist.

X-rays to be sent to reception.westpole@colosseumdental.co.uk

Would you like us to provide?

☐ Second Opinion	☐ Treatment

Reasons for referral

We will take a full medical history and ask the patient to sign consent forms prior to an examination/treatment. The referring dentist can request a copy of these documents.

Referral letter for implant treatment

Yeovil Dental Clinic
1 High Street, Yeovil,
Somerset, BA20 1RE

E: reception.yeovil@colosseumdental.co.uk

01730 810010

colosseumdental.co.uk

Referring Dentist Details

Dentist name	
GDC No.	
Dentist email	
Practice name and address	
Practice Tel.	
Practice email	

Patient Details

Name	
DOB	
Address	
Home Tel.	
Mobile Tel.	
Email	
Notes	

Referral for implant treatment

Please read and tick the boxes

- ☐ I am the Dentist/Hygienist
- ☐ I am referring the patient for the reasons outlined below

Dentist/Hygienist signature	
Date	

Please note that patients are expected to pay either in advance or on the day, prior to seeing the dentist.

X-rays to be sent to reception.yeovil@colosseumdental.co.uk

Would you like us to provide?

☐ Second Opinion	☐ Treatment

Reasons for referral

We will take a full medical history and ask the patient to sign consent forms prior to an examination/treatment. The referring dentist can request a copy of these documents.

Referral letter for implant treatment

Portland Street
Dental & Implant Clinic
23/25 Portland Street,
Aberystwyth, Ceredigion, SY23 2DX

E: reception.portlandstreet@colosseumdental.co.uk
01970 612581

colosseumdental.co.uk

Referring Dentist Details

Dentist name	
GDC No.	
Dentist email	
Practice name and address	
Practice Tel.	
Practice email	

Patient Details

Name	
DOB	
Address	
Home Tel.	
Mobile Tel.	
Email	
Notes	

Referral for implant treatment

Please read and tick the boxes

☐ I am the Dentist/Hygienist
☐ I am referring the patient for the reasons outlined below

Dentist/Hygienist signature	
Date	

Please note that patients are expected to pay either in advance or on the day, prior to seeing the dentist.

X-rays to be sent to reception.portlandstreet@colosseumdental.co.uk

Would you like us to provide?

☐ Second Opinion	☐ Treatment

Reasons for referral

We will take a full medical history and ask the patient to sign consent forms prior to an examination/treatment. The referring dentist can request a copy of these documents.

Llythyr atgyfeirio am driniaeth mewnblannu

Portland Street Dental & Implant Clinic
23/25 Portland Street,
Aberystwyth, Ceredigion, SY23 2DX

E: reception.portlandstreet@colosseumdental.co.uk
01970 612581

colosseumdental.co.uk

Manylion y Deintydd Atgyfeirio

Enw'r deintydd	
Rhif GDC	
E-bost y deintydd	
Enw a chyfeiriad y practis	
Rhif ffôn y practis	
E-bost y practis	

Manylion y Claf

Enw	
Dyddiad geni	
Cyfeiriad	
Rhif ffôn cartref	
Rhif ffôn symudol	
E-bost	
Nodiadau	

Atgyfeiriad am driniaeth mewnblannu

Darllenwch a thiciwch y blychau

☐ Fi yw'r Deintydd/Hylenydd
☐ Rwyf yn atgyfeirio'r claf am y rhesymau a amlinellir isod

Llofnod y Deintydd/ Hylenydd	
Dyddiad	

Sylwch fod disgwyl i gleifion dalu naill ai ymlaen llaw neu ar y diwrnod, cyn gweld y deintydd.

Dylai pelydrau-X gael eu hanfon at reception.portlandstreet@colosseumdental.co.uk

A hoffech i ni ddarparu?

☐ Ail Farn	☐ Triniaeth

Rhesymau am yr atgyfeiriad

Byddwn yn cymryd hanes meddygol llawn ac yn gofyn i'r claf lofnodi ffurflenni cydsynio cyn archwiliad/triniaeth. Gall y deintydd sy'n atgyfeirio ofyn am gopi o'r dogfennau hyn.

Referral letter for implant treatment

Handside Dental Clinic
178 Handside Lane,
Welwyn Garden City,
Hertfordshire, AL8 6SZ

E: reception.handside@colosseumdental.co.uk
01707 323 250

colosseumdental.co.uk

Referring Dentist Details

Dentist name	
GDC No.	
Dentist email	
Practice name and address	
Practice Tel.	
Practice email	

Patient Details

Name	
DOB	
Address	
Home Tel.	
Mobile Tel.	
Email	
Notes	

Referral for implant treatment

Please read and tick the boxes

- ☐ I am the Dentist/Hygienist
- ☐ I am referring the patient for the reasons outlined below

Dentist/Hygienist signature	
Date	

Please note that patients are expected to pay either in advance or on the day, prior to seeing the dentist.

X-rays to be sent to reception.handside@colosseumdental.co.uk

Would you like us to provide?

☐ Second Opinion	☐ Treatment

Reasons for referral

We will take a full medical history and ask the patient to sign consent forms prior to an examination/treatment. The referring dentist can request a copy of these documents.

Referral letter for implant treatment

Little London Dental Clinic
31 Little London, Chichester,
West Sussex, PO19 1PL

E: reception.littlelondon@colosseumdental.co.uk

01243 782 878

colosseumdental.co.uk

Referring Dentist Details

Dentist name	
GDC No.	
Dentist email	
Practice name and address	
Practice Tel.	
Practice email	

Patient Details

Name	
DOB	
Address	
Home Tel.	
Mobile Tel.	
Email	
Notes	

Referral for implant treatment

Please read and tick the boxes

☐ I am the Dentist/Hygienist
☐ I am referring the patient for the reasons outlined below

Dentist/Hygienist signature	
Date	

Please note that patients are expected to pay either in advance or on the day, prior to seeing the dentist.

X-rays to be sent to reception.littlelondon@colosseumdental.co.uk

Would you like us to provide?

☐ Second Opinion ☐ Treatment

Reasons for referral

We will take a full medical history and ask the patient to sign consent forms prior to an examination/treatment. The referring dentist can request a copy of these documents.

Referral letter for implant treatment

Amelia Street Dental Clinic
22 Amelia Street,
London, SE17 3BZ

E: reception.ameliastreet@colosseumdental.co.uk

020 7703 5601

colosseumdental.co.uk

Referring Dentist Details

Dentist name	
GDC No.	
Dentist email	
Practice name and address	
Practice Tel.	
Practice email	

Patient Details

Name	
DOB	
Address	
Home Tel.	
Mobile Tel.	
Email	
Notes	

Referral for implant treatment

Please read and tick the boxes

- ☐ I am the Dentist/Hygienist
- ☐ I am referring the patient for the reasons outlined below

Dentist/Hygienist signature	
Date	

Please note that patients are expected to pay either in advance or on the day, prior to seeing the dentist.

X-rays to be sent to reception.ameliastreet@colosseumdental.co.uk

Would you like us to provide?

☐ Second Opinion	☐ Treatment

Reasons for referral

We will take a full medical history and ask the patient to sign consent forms prior to an examination/treatment.
The referring dentist can request a copy of these documents.

Referral letter for implant treatment

Arnot Hill Dental Clinic
82-84 Nottingham Road,
Arnold, Nottingham, NG5 6LF

E: reception.arnothill@colosseumdental.co.uk

01159 265822

colosseumdental.co.uk

Referring Dentist Details

Dentist name	
GDC No.	
Dentist email	
Practice name and address	
Practice Tel.	
Practice email	

Patient Details

Name	
DOB	
Address	
Home Tel.	
Mobile Tel.	
Email	
Notes	

Referral for implant treatment

Please read and tick the boxes

- ☐ I am the Dentist/Hygienist
- ☐ I am referring the patient for the reasons outlined below

Dentist/Hygienist signature	
Date	

Please note that patients are expected to pay either in advance or on the day, prior to seeing the dentist.

X-rays to be sent to reception.arnothill@colosseumdental.co.uk

Would you like us to provide?

☐ Second Opinion	☐ Treatment

Reasons for referral

We will take a full medical history and ask the patient to sign consent forms prior to an examination/treatment. The referring dentist can request a copy of these documents.

Referral letter for implant treatment

Hanlon and Gardner Dental Practice
30 New Road, Chippenham,
Wiltshire, SN15 1HP

E: reception.chippenham@colosseumdental.co.uk

01249 652259

colosseumdental.co.uk

Referring Dentist Details

Dentist name	
GDC No.	
Dentist email	
Practice name and address	
Practice Tel.	
Practice email	

Patient Details

Name	
DOB	
Address	
Home Tel.	
Mobile Tel.	
Email	
Notes	

Referral for implant treatment

Please read and tick the boxes

☐ I am the Dentist/Hygienist
☐ I am referring the patient for the reasons outlined below

Dentist/Hygienist signature	
Date	

Please note that patients are expected to pay either in advance or on the day, prior to seeing the dentist.

X-rays to be sent to reception.chippenham@colosseumdental.co.uk

Would you like us to provide?

☐ Second Opinion	☐ Treatment

Reasons for referral

We will take a full medical history and ask the patient to sign consent forms prior to an examination/treatment. The referring dentist can request a copy of these documents.