WEST DENTAL IMPLANTS & PROSTHETICS

Date of Referral _____

Referred by Dr. _____

Introducing my Patient _____

Patient Phone _____ Age _____

Patient Address _____

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

- ☐ Implant placement
- ☐ Soft/hard tissue grafting for implant placement
- ☐ Failing Implant/laser LAPIP protocol
- ☐ Fixed Prosthodontics (Comprehensive rehabilitation, Wear case, Fixed implant supported prosthesis [hybrid, Zirc, PFM])
- ☐ Removable Prosthodontics (Dentures, Partial Dentures, Overdentures, Telescopic, Implant supported overdentures [locator, hader bars, precision attachments])
- ☐ Extraction(s)
- ☐ TMD evaluation & treatment
- ☐ Sleep medicine & associated sleep apnea appliance
- ☐ Cosmetic/aesthetic evaluation/treatment
- ☐ Special needs patient

☐ **Referring doctor to restore case** **OR** ☐ **Dr. Robison to restore case** (requires written instructions or phone consultation)

Notes _____

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