straumann®

IMPLANT REFERRAL

I request that a Straumann® dental implant be used in this case.

Referring doctor: ______________________________

Patient information: ______________________________

Patient phone/email: ______________________________

Proposed implant placement at tooth/teeth:

❐ 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

Straumann Implant Information:

Type of Implant: ❐ Bone Level ❐ Tissue Level

Implant Material: ❐ Titanium ❐ Roxolid®

Surface: ❐ SLA® ❐ SLActive®

Proposed prosthetic option(s) discussed with patient:

❐ Immediate temporization
❐ Implant supported fixed appliance
❐ Single crown
❐ Implant supported removable appliance
❐ Early load (3-4 weeks)
❐ Multi-unit bridge/crowns
❐ Other ______________________________

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Discussed bone grafting: ❐ Yes ❐ No

Other remarks: ______________________________

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______________________________ ______________________________
Referring doctor signature Date

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