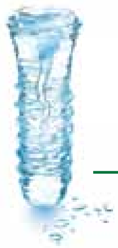

straumann

SLActive™ IMPLANT REFERRAL

I request that a Straumann® SLActive™ Dental Implant be used in this case.

Referring doctor: ____________________

Patient name: ____________________

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

Proposed prosthetic option(s) discussed with patient:

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

SLActive™

The surface with success built in.™

Discussed implications of bone grafting: ☐ Yes ☐ No

Remarks:

Referring doctor signature Date