straumann®

MAKE MINE ROXOLID® FOR ALL

IMPLANT REFERRAL

I request that a Straumann Roxolid For All 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 discussed with patient:

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

Discussed implications of bone grafting: ❒ Yes ❒ No

Remarks: _____

_____

_____ _____

Referring doctor signature Date

8/13 USLIT 484

COMMITTED TO
SIMPLY DOING MORE℠
FOR DENTAL PROFESSIONALS