INDIANA UNIVERSITY

SCHOOL OF DENTISTRY

Implant Center
IUPUI

Referral Form

Date _____

Patient's Information

Name _____ Phone _____

Address _____
_____

Referring Doctor's Information

Name _____ Phone_____

Address _____
_____

Reason For referral

Referred to: ___ Oral Surgery ___ Perio ___ No Preference

___ Consultation Only ___ Implant Placement ___ Abutment Placement ___ Implant Restoration

Select desired implant system: ___ Nobel Biocare ___ Straumann ___ Zimmer ___ Biomet 3i ___ Astra
___ Other:_____

Area(s) of concern: (circle) 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

___ X-rays Available ___ Sent with Patient ___ Mailed

Adjunctive Treatment: ___ Sinus Lift ___ Bone Grafting ___ Extraction ___ IV Sedation

Please send completed Referral Form to:

Indiana University School of Dentistry
1121 W. Michigan St., Room S306D
Indianapolis, IN 46202
Fax# 317-278-2818

For Appointments call #(317)278-1840

Please note this form **is not** to be sent electronically.