



IMPLANT
TEAM
ACADEMY

PATIENT REFERRAL

Dr Alex Fibishenko BDSc FICOI

PRACTICE EXCLUSIVE TO IMPLANT
& RECONSTRUCTIVE DENTISTRY

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Patient Information

Surname	Mr / Mrs / Miss Ms / Dr	Other Names
D.O.B	Age	Tel.
Home Address	P/C	

Reason for Referral

- | | | |
|---|--|--|
| <input type="checkbox"/> Second Opinion | <input type="checkbox"/> Treatment as Required | <input type="checkbox"/> Surgical Implant Placement Only |
| <input type="checkbox"/> Sinus Graft | <input type="checkbox"/> Onlay Bone Grafting | <input type="checkbox"/> Management of Complication |
| <input type="checkbox"/> Extraction & Socket Preservation | <input type="checkbox"/> Extraction & Immediate Implants | <input type="checkbox"/> Immediate Function |
| <input type="checkbox"/> All-On-4 | <input type="checkbox"/> NobelGuide Surgical Planning | <input type="checkbox"/> Soft Tissue Surgery |

Further Details: _____

Attachments: Photographs OPG CT Scans PA's Surgical Stent

Referring Practitioner

Name	Tel.
Address	P/C
Signature	Date

- I will be attending for the procedures
- I am registered with Implant Team Academy
- I'd like to perform certain components of the procedure at your clinic