



UK Dental Specialists  
at Chiswell Green

# Journal of Specialist Dentistry

Developing Dental Expertise

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## Welcome to the Summer edition of JSD

Editor, Dr Massimo Peru BDS, MSc Endo

This 15th edition showcases two excellent studies in very interesting fields: an Orthodontic Case Study by Specialist Dr Luisa Lucchesi on 'Management of missing Upper Lateral Incisors'; a Periodontal Case Study by Specialist Periodontist Dr Dhru Shah on 'The role of Microscopes in Periodontal Plastic Surgery' and an article about compliance – 'The Shocking Tale of Dental water Lines Treatment' from Piotr Leszkiewicz - Independent Legionella Consultant at The First Principle Group Ltd.

We are also welcoming a new Endodontic Specialist to the UKDS team; Dr Aisling Quinn!

For more information about Aisling visit us on: [www.UKDentalSpecialists.co.uk](http://www.UKDentalSpecialists.co.uk)

To keep up to date on case studies and practice information, visit our Facebook page – UK Dental Specialists at Chiswell Green

If you are interested in developing your knowledge and practical skills, details of the new CPD seminar events organised by our partners at UK Dental Specialists can be found at page 12. The seminars are free of charge and valid for two CPD hours.

You can also receive a 1 hour verifiable CPD from our Journal of Specialist Dentistry by answering the questions on page 11 and emailing them to:

[Info@UKDentalSpecialists.co.uk](mailto:Info@UKDentalSpecialists.co.uk). We will then post you your certificate!

**Best wishes, Dr Massimo Peru, Chief Editor**

## *The Art of Dental Excellence*



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## Management of missing upper lateral incisors by Dr Luisa Lucchesi

Maxillary lateral incisors are one of the most common teeth to be absent with an incidence of 1-2% in Caucasians. Lateral incisors may be unilateral or bilaterally absent. The absence of maxillary incisors generally follows an autosomal dominant mode of inheritance with incomplete penetrance.

### Why are missing lateral incisors a problem?

Generally, the major concern relates to the dental aesthetics, in particular, spacing, rotations and centreline deviation. An asymmetrical smile may also be of concern, specifically in the case of an absent single maxillary lateral incisor as the contralateral incisors are commonly diminutive and peg-shaped. It has also been reported that a link exists between the absence of maxillary incisors and ectopic permanent canines. (Brin et al, 1986). The root of the maxillary lateral incisor is thought to have an important role in guiding the eruption of the permanent canine into the correct position.



Pre Op - Case 1



Pre Op - Case 2



Pre Op - Case 3

### CASE REPORT

A woman presented in her early twenties, unhappy with her anterior dental aesthetics. The upper right lateral incisor was congenitally missing and had been prosthetically replaced with a resin bonded bridge. Although the bridge had been successful, the patient was also unhappy with the size of the



Pre Treatment - Right



Pre Treatment - Centre



Pre Treatment - Left

prosthetic tooth and that she had an increased overjet. The contralateral upper lateral incisor was also diminutive. She had received no previous orthodontic treatment.

### Clinical Examination

The skeletal relationship can influence the treatment approach, in particular the decision as to whether the space associated with a missing lateral incisor should be closed or re-opened/redistributed for a prosthetic replacement.

In this case, this patient presented with a mild skeletal II pattern. As the patient was an adult, correction of the skeletal discrepancy would be by orthodontic camouflage and therefore space to retract the upper incisors was necessary. Typically this would involve the extraction of upper premolar

units, however, since one upper lateral incisor was already missing, the options to be considered by the patient were:

1. Removal of the resin bonded bridge, extraction of the contralateral upper lateral incisor and close the anterior space, camouflaging the upper canines as lateral incisors.
2. Extraction of 2 upper premolar units, reduction of the overjet and replacement of the resin bonded bridge with a new prosthetic replacement.

A soft tissue assessment is also important and the amount of gingival tissue exposure at rest and on smiling should be assessed. When considering space closure, the emergence profile of the canine might differ from the contralateral tooth or be out of balance with the central incisor teeth. A canine with a narrow mesiodistal width at the CEJ will produce a more aesthetic emergence profile (Senty EI, 1976).

### Canine Considerations

The aim is to create an aesthetic arrangement of teeth that have a colour, size and morphology which are within normal limits. When closing missing lateral incisor space with a canine, the ideal scenario would be one where its dimensions are similar to the tooth it is replacing. A pointed canine can be trimmed and can be restored, it is possible the mesio-incisal edges of the canine to recreate normal lateral contours. A slightly wider canine, as with the presenting patient, can be reduced, but a bulky canine and broad tooth would not be in harmony with the surrounding dentition.

It is also not unusual for canines to be darker in colour and this may be very noticeable once space closure has occurred. Restorative options to address this may include bleaching or veneering.

### Diagnostic set-up

Having favoured option 1, to remove the prosthetic upper right lateral incisor and extract the contralateral upper left lateral incisor, a diagnostic set up was utilised to provide a visual tool a go to the patient's the likely orthodontic outcome.

### Treatment

The patient was seen by her dentist for removal of the resin bonded bridge (UR2) and extraction of the upper left lateral incisor. The following week, upper and lower ceramic fixed appliances were placed. Correct bracket placement is important when undertaking canine substitution. A canine bracket may be placed on the canine but inverted. This allows for palatal root torque to be applied in order to reduce the prominence of the canine eminence and help replicate the



Post Treatment - Centre



Post Treatment - Right



Post Treatment - Left

lateral root position (Thickett et al, 2007).

Following approximately 15 months of treatment, the upper anterior space had been closed. The canine tips were levelled and the patient decided against any further composite build up or vital bleaching of the upper canines.

### Post orthodontic retention

For this patient, the tendency of the space to re-open is overcome with properly finished occlusal contacts and long-term retention using bonded retainers supplemented with lifelong wear of vacuum formed clear retainers.

### Conclusion

It is essential to address the functional and aesthetic concerns that the patient presents with. A detailed clinical and radiographic examination are required and visual tools such as diagnostic set-ups are all important components of the planning process.



## The role of magnification and the microscope in periodontal plastic surgery

Some months ago, I discovered the microscope. At UK Dental Specialists, our endodontists constantly use microscopes for the high quality endodontic treatment that they provide. I am positioned in the same surgery and decided to start using the microscope for some of the initial work.

The initial use of the microscope was a steep learning curve

### Where did I start :

Quite simply, I started by asking the endodontic specialists about the different components of the microscope and which ones were most critical. The interpupillary distance was significant along with the position of the microscope. Once I had this correct, I placed a tooth model on the chair and began to orientate myself. I had two periodontal probes (one in each hand) and I continue to attempt to touch the tips of the two probes to each other while viewing under the microscope. This exercise was hugely beneficial in helping me get orientated and understand the difference in our perception that comes at magnification. I started with the lowest magnification on the scope and that is where I have used it since.

In addition, the position of the microscope hugely improves posture. In order to get the correct position, and orientation, posture is important. Here you see in the above image how I have developed a rather upright back, healthy posture. Ergonomically, this makes a lot more sense to me.

Once I felt confident, I slowly started using it for some of the patient examinations and then for non surgical root surface debridement. The difference in the usage of microscopes in endodontics vs periodontics is this in endodontics, they have one tooth which is stagnant that they treat. Most times the access is occlusal. Thus, once the position of the microscope is fixed, they can continue to operate. In periodontics, we operate on multiple teeth (normally a quadrant or a sextant at a time) therefore the microscopic field of view, must cover multiple teeth – and one has to have the ability to view the buccal aspects, palatal aspects and interproximal aspects. This made it a challenge. Eventually I found that the best way to approach this was to keep the microscope and my posture stagnant and ask the patient to move their head. This was another positive step within the learning curve.

Once I felt comfortable with this, I moved onto using the



microscope for periodontal surgical procedure and then microsurgical and periodontal plastic surgery. Here are some of the significant changes, that using microscopes has had on my surgical procedure: that is using a microscope.

1. Changing the type of blades. I had already moved from using I5c blades to microsurgical blades. However microscopic magnification has enabled me to use minimicrosurgical blades
2. Tissue handling. I always thought I handled tissue delicately. However using a microscope shows tissue handling with even greater detail and thus tissue handling has improved
3. Suturing. The entire suturing technique has improved significantly. Once again attributable to the visualisation of greater detail

The main significance is the greater detailed visualisation. This kind of visualisation is key in periodontal plastic and soft tissue procedures to reduce trauma, improve tissue handling and gain much improved long term outcomes. Here I show you a case carried out using a microscope. The images are taken as screenshots from the video taken through the microscope. I can now take videos and then review the videos of such procedures to constantly improve my techniques and gain optimal results. This has an even greater impact than photographs as every single movement is noted in detail.



Pre Op



1. The above image is the pre operative photographic picture:

There is recession associated with both the lower central incisors. The majority of the recession is in the midpoint of the teeth and it is past the mucogingival junction and there is associated interproximal tissue loss but that is limited. There was very limited attached keratinised tissue. As you can imagine, the absence of keratinised tissue, combined with the recession, would make oral hygiene difficult around these areas. The patient was experiencing soreness and bleeding during brushing and cleaning. The cleaning was not optimal either due to difficulty in access.

The decision was initially to do a free gingival graft. As you will have noted from my previous cases in this journal, the free gingival graft is beneficial because it helps augment attached tissue and this helps with oral hygiene. The intention of a free gingival graft is not to cover the receded root surfaces.

However in this specific and rare case, you will see that I modified the technique to gain some root coverage.

2. In this section you will see the images from the microscope footage as I explain the case and how microsurgical visualisation and procedures helped me deliver a better result:

2a. The initial step was to debride the root surface both supragingivally and subgingivally. In most cases, the oral hygiene should be optimal to carry out soft tissue surgery. However in this case, this was difficult for the patient and the indication for doing the free gingival graft was to aid in improving the oral hygiene. Therefore there was likely to be plaque biofilm and this had to be removed prior to surgery to ensure having as clean root surfaces as possible. Microscopic magnification and visualisation enabled me to view this in much greater detail to get the best possible outcome.

The later images allow you to see the ultrasonic tip in order to assess the level of magnification and how clear this is.

2b. The above four images show my next step. Normally in

a free gingival graft, the technique does not employ the incision of the tissues at the gingival margin. This is because we are simply augmenting keratinised tissue and the incision involves creating a "pouch" with a split thickness incision at the mucogingival junction. However, in this case, I decided to do some tunnelling prior, to this. The reasoning behind this was that there was enough interproximal tissue for me and I thought that if I was inserting keratinised tissue at and below the level of the mucogingival junction, I could also tuck in the superficial part of the graft beneath the tissue coronal to the mucogingival junction, and actually coronally position it. To be able to achieve this level of fine tissue movement, I felt magnification hugely helped me. If you look at the 4 images above where I used the minimicro blade and the tunnelling instruments, you will see how well I could visualise this to ensure delicate tissue movement and reduce the trauma and tears to as little as possible.

2c. It was only after I had mobilised this tissue well, that I proceeded to create the pouch for my free gingival graft. It was a split thickness incision. First the incision is made perpendicular to the tissue at the mucogingival line and then the blade is angle parallel to the tissue and extended apically to create the split thickness incision. This eventually creates a pouch into which the free gingival graft with be augmented too. The periosteum provides the blood supply.

2d. At this point, in most cases, a template such as the cardboard of the suture material is used and the measurement is done with a periodontal probe to gain the approximate dimensions needed for the free gingival graft. The one difference I made was to make the height of the free gingival graft 3 mm greater as this aspect will be tucked under the coronal tissues. This was a modification to the technique.

The free gingival graft was raised. At this point I have to admit that achieving microscope magnification in the palate



was not easy. I therefore raised the graft with direct vision. Subsequently I have now started using indirect vision (with an occlusal mirror) to carry out surgical procedures in the palate.

An important point to stress here is that unlike loupes, where the clinician is more mobile, with a microscope both the scope and the clinician are in a static position. Ergonomically this is very useful, but one must build the skill to be able to carry out surgical procedures with indirect vision when using the microscope.

2e. Once the graft was raised, the graft was thinned to remove any fatty tissue. Magnification is very useful here as it enables one to be able to visualise with greater detail and thus, be able to really trim it to adequate thickness. In addition, the coronal 3mm of the graft was also de-epithialised as it was going to sit under the coronal pouch.

2f. The graft was then inserted to the recipient site. Normally the graft is then sutured carefully to the adjoining attached tissue to ensure that it is secure. However in this case, with the modification, the graft was first tucked in under the coronal tissue

Magnification was useful for this, as it enabled me to view in detail to carefully handle the tissues

2g. Suturing was done. Here are some images that

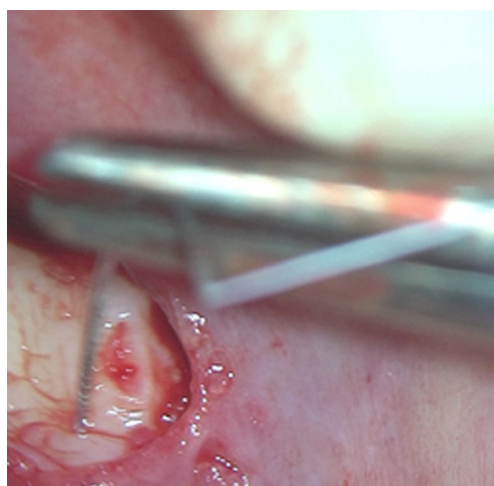
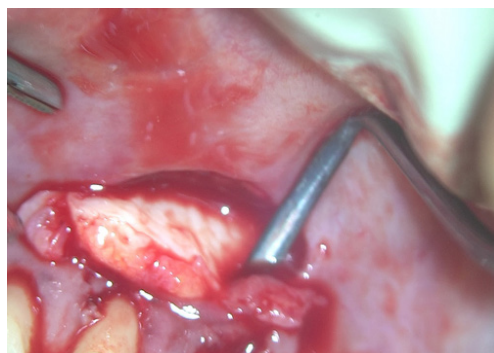
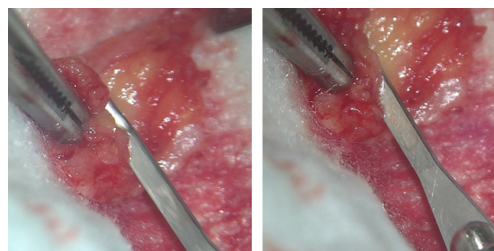
indicate the level of magnification with which one can visualise to enable accurate and adequate suturing.

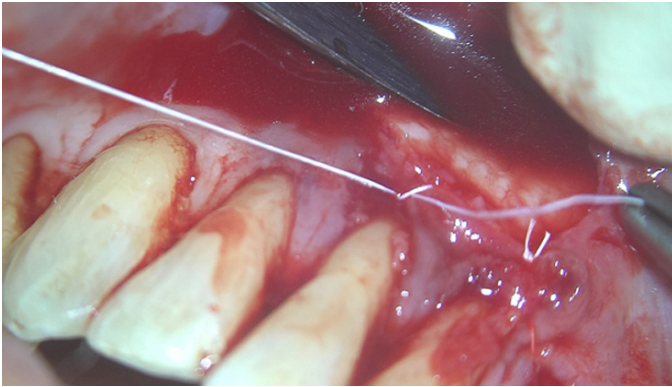
One of the coronal corners is sutured first as one does with the conventional free graft. However in this case, the only difference was that the donor tissue was not a corner but a lateral edge as the corner had been tucked underneath the coronal tissue

The remaining coronal sutures and the periosteal sutures were done to stabilise the free graft.

Here is the final graft after all the suturing.

3. The patient was reviewed 2 weeks later and these





post operation pictures below show the healing. Compare the post operative to the pre operative pictures to assess the improvement in keratinised tissue that has begun and the partial root coverage achieved.

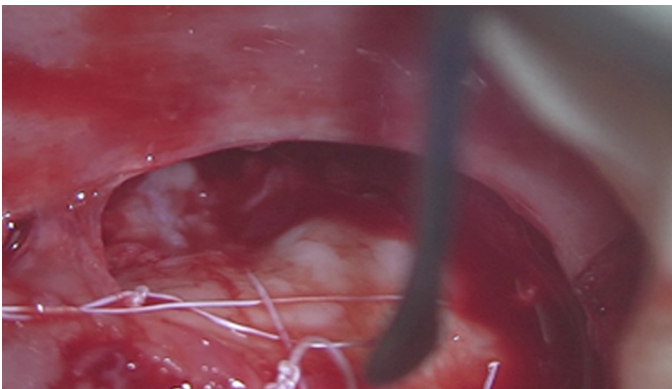
#### Conclusion:

This case illustrates the benefits of microsurgical techniques on improving soft tissue procedures. While often, such procedures are carried out to improve tissue quality (i.e. attached tissue improvement) OR to improve root surface recession coverage, in this case a modified technique was employed to enable achievement of both options. Microsurgical magnification and vision helped me achieve this with greater confidence.

Have you got any recession cases that would benefit from these cases? This is perhaps the third case I have illustrated within this journal. (The previous 2 cases were in Editions – 9 and 13 If you wish to have these journal issues again kindly let us know.)

We hope you have gained a deeper understanding of the benefits of the free gingival graft and what it can achieve.

Are there any specific case situations you have where you would like us to illustrate their management? Please do contact us so I can write more on the management of soft tissue defects, how to correct them and how magnification can achieve additional benefits





## THE SHOCKING TALE OF DENTAL WATER LINES TREATMENT

Dental unit waterlines are all the rage these days. On the surface, it can seem easy to tell the treatment options apart. Application, cost, and longevity are all important factors when selecting a waterline treatment solution. However, first, you want to know if the product you're spending money on actually works and will keep your dental lines safe.

After all, getting dental unit waterlines clean so you can deliver safe water into your patients' mouths and protect yourself (dentist) and your staff (dental nurses), is why you're working on waterline maintenance protocol in the first place!

### THE LARGEST WATERLINE TREATMENT EFFICACY STUDY TO DATE

In 2017, a company in USA conducted the most extensive dental waterline treatment efficacy study to date. Compiling data from over 22,000 consecutive waterline tests, this study shows vital real-world statistics of product performance in the marketplace.

Of these 22,000+ consecutive waterline tests, all samples were taken directly from clinical practices and provided by those practices. Treatment information was provided by dental practices as well.

Every sample was tested using the R2A heterotrophic plate count method. All tests were blind and utilised approved standard methods to ensure accuracy. All pass/fails were measured against the US standard for safe water of  $\leq 500$  CFU/ml, which is much more forgiving than UK standard for drinking water quality  $\leq 200$  CFU/ml

### HTM01-05 - Paragraph 6.79

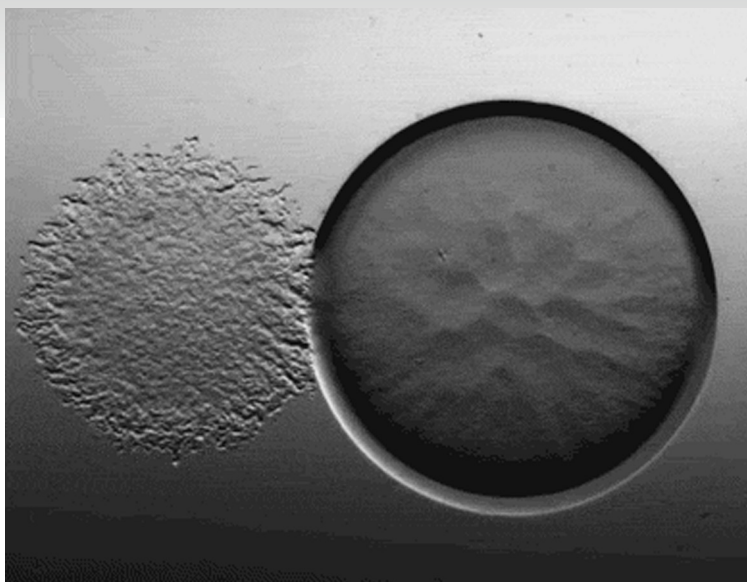
*"Where monitoring is undertaken, the TVC should be expected to lie in the range 100 to 200 colony forming units per millilitre (cfu/ml). In general, incubation should be at 22°C. These measurements can be carried out by commercial microbiological services or by Public Health England."*

### So, what are the key findings from the study?

Overall, 31% of treated waterlines failed to meet the US Standard of  $\leq 500$  CFU/mL, which means they have also failed the UK standard too.

However, tablets with an accompanied shock product showed the best results. A handful of product combinations were above 90% pass rate; however, these did not have extensive data sets.

Straws and cartridges passed at 72% on average.



Shock treatments used by themselves – with no accompanied continuous or daily treatment products – performed similarly well to everyday liquids and centralised systems at 60% or below.

So, how can treated waterlines fail this often?

This is for a few reasons. However, first, let's be clear: most of the products used in dental practices across the world are great products. Each of the treatment types and specific products have features and benefits that can be appreciated. But often, how products are sold is different than how they work in the real world.

These are the most common reasons we've found for poor performance:

#### 1. Sold with Unrealistic Expectations

Products are often sold as maintenance-free, and unfortunately, none of them are.

A quick review of the instruction manuals shows that each product requires close attention and a little elbow grease to be effective. Whether that involves testing your water hardness, daily water bottle drying, water bottle washing, or performing a protocol multiple times to start, make sure you review the instructions for use on a manufacturer's (not just supplier's) website to know what a product requires.

#### 2. Misunderstanding the science of low-level antimicrobials vs biofilm

There are two kinds of dental waterline treatment products: continuous treatments (low-level antimicrobials) and shock treatments (high-level disinfectants).

Continuous treatments contain low-level antimicrobials that maintain already clean lines while also being safe for patient contact. They continuously fight bacteria within the lines.

Shock treatments contain high-level disinfectants that are strong enough to remove biofilm. They effectively remove (or "shock the system") bacteria and biofilm but are not safe for patient contact.

Shock treatments clean the waterlines. Continuous products maintain the already clean lines for longer before another shock treatment is required. When used together, pass rates go way up. When used separately, results are wildly inconsistent.

#### The shock treatment should be repeated regularly:

Shock Every 1-3 Months - The best products recommend shocking your dental unit waterlines between 1-3 months. Effective resistance against microbial growth slowly diminishes within this timeframe and biofilm counts can quickly rise towards the maximum 200 CFU/mL limit. During the disinfection, planktonic organisms will be destroyed, but even if the majority of the microorganisms in the



biofilm are eliminated, the architecture of the biofilm survives and acts as a pre-formed matrix for renewal of the biofilm.

You'll hear from some product reps that shocking isn't necessary with certain products. We've not found this to be proven. Shocking your dental waterlines consistently purges out the regrown bacteria, restores a clean environment for continuous treatment, and ensures safe dental water.

**Shock Every Week** - Without using any dental water treatment (maintenance) products designed to be in your waterlines continuously, biofilm can re-attach and begin growth immediately after shocking your waterlines. Studies have shown that within five days, bacteria counts can grow to 200,000 CFU/mL. This method of maintenance requires consistent attention, and shocking less than once a week can put your patients and practice at risk.

Always check the manufacturer's instructions for your equipment and shock product. Different chair manufactures suggest different shock protocols and different treatment products call for different techniques and frequencies. However, if someone tells you that you don't have to do any shock treatment because you use their magic product, think twice and ask yourself, is that a pro-active or re-active approach?

### 3. Poor Product Instructions for use!

Some products have instructions-for-use that suggest shocking is not necessary for safe waterlines, and some say that you only need to do shocking of lines when your "dip slides" or "HPC Samplers" detect contamination. Once again, ask yourself, is that a pro-active or re-active approach?

The data from this study proves otherwise. Here at The First Principle Group Ltd, we recommend that you don't ignore the best-known guidance, which is HTM01-05.

We also highly recommend using both a shock treatment and a continuous treatment, even if a sales rep says you do not need to. As this is in line with the approved guidance:

**"HTM01-05 P.6.86 Disinfection of DUWLs should be carried out periodically."**

If you do that, you'll see it's never just twist or drop and you're done.

Also, to verify your protocol is sufficient, you could consider quarterly UKAS Accredited TVC Waterline Sampling. However, this is not a legal requirement and in line with the HTM01-05 "19.66 Apart from situations where there are taste or odour problems, microbiological monitoring for total viable counts (TVCs) is not considered to be necessary."

**"19.68 All microbiological measurements should be by approved methods and/or be carried out by United Kingdom Accreditation Service (UKAS)-accredited laboratories. Dip slides are not acceptable."**

PS. We have seen user manuals in Chinese only, being distributed in the UK

Very often, we hear practices saying this:

"We only use XXXX product and we don't need any shock treatment. We also do dip slides and never have any problems..."

.... and then we see this:

Once again, apart from situations where there are taste or odour

problems, microbiological monitoring for total viable counts (TVCs) is not considered to be necessary!

Use your senses! If it doesn't look clean, it's probably not clean and if dip slides don't detect anything you should ask yourself why?

### 4. Underlying equipment issue

Lastly, and this is much less common, there can be an underlying equipment issue that can lead to poor failure rates. Sometimes, it can be as simple as an unknown toggle that switches some devices between sources (mains or independent water bottles). We've also seen some very old waterlines that have been building up biofilm for years. Other times, it can be dead legs that create stagnant water perfect for biofilm development that feed bacteria into the other lines and overwhelms the products. Sometimes it can be a filter or water distiller problem.

### WHAT SHOULD OUR PRACTICE DO?

Each practice is different and should choose the right treatment protocol based on those unique needs. And again, each of these product types can be very effective. It's just that they can fail, too. Unfortunately, there is no one waterline maintenance magic product!

**However, there are simple steps you can take to ensure your practice has a proven protocol.**

1. Balance Effectiveness with Convenience - review product instructions closely to see what is required but most of all familiarise yourself with HTM-01-05 and its requirements
2. Ensure you have clear legionella management written scheme (the plan of action) that includes dental unit water lines management
3. Make sure your written scheme is fully implemented, and all staff do what you ask them to do
4. Combine Continuous treatment (ongoing maintenance) with Shock Treatment - always use both a shock treatment and a continuous treatment if you want consistently safe waterlines and show proactive management.
5. Review your risk assessment, and if you use external consultants, makes sure they are competent and have sufficient knowledge and experience. Very often, we see dental practice legionella risk assessment's that don't even mention dental equipment, which makes this risk assessment inadequate.

Best wishes,

Piotr Leszkiewicz  
Independent Legionella Consultant  
The First Principle Group Ltd

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# MORE INVENTIVE LESS INVASIVE



## BUSINESS BITE BACK



### Dental Records – who is entitled to access them?

A common question we are asked whether a dental practice is obliged to disclose notes to officials, such as the police or social services. Whilst GDPR is in everyone's minds right now, a practice also needs to consider professional duties of confidentiality, the common law duty to disclosure in the public interests and the rules contained within the Access to Health Records Act (1990).

#### 1. Living Patient's Records

If you receive a request from an external body, such as the police or social services, in respect of a living patient's records, you must consider this carefully before disclosing anything. There is no automatic right to access, not even for the police.

Unless there is a specific court order, you will need to consider whether the disclosure would be justified in the 'public interest'. An example might be if either the patient or someone else was at risk of **serious and imminent** harm if the notes are not disclosed. You should try to seek consent first, but if this is not possible weigh up what is being requested against why it is needed to decide whether

disclosure would be justified. Make a clear record of why you have reached the decision you have reached.

#### 2. Deceased Patient's Records

The duty of confidentiality extends beyond the death of a patient. Ultimately, if the patient explicitly states whilst alive that they do not want their records disclosed on death, then this wish must be adhered to.

The Access to Health Records Act (1990) allows access to records to two defined categories, namely:

1. The patient's personal representative;
2. Any person who may have a claim arising out of the patient's death.

You do not need to provide access to all of the dental records when requested by the above, only information that is relevant to any claim being pursued.

You may also receive a request to access the notes of a deceased patient from a coroner. They have a legal obligation placed on them to investigate the death, so you must provide them with access to the records.

Finally, providing documents to the police to identify a body would be justified.

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E: [info@jfhlaw.co.uk](mailto:info@jfhlaw.co.uk)  
W: [www.jfhlaw.co.uk](http://www.jfhlaw.co.uk)  
Twitter handle: @thetoothcounsel

## CPD Questions

1. Dr Shah quickly learned he would have to adjust the way he uses the microscope during examinations from a periodontists point of view compared to an endodontist. To achieve the optimum view of all tooth surfaces and soft tissues, he would have to...

- a- Adjust the position of the microscope during examinations  
b- Adjust the magnification settings  
c- Ask the patient to adjust the position of their head while the microscope stays stagnant

2. Without using any dental water treatment (maintenance) products designed to be in your waterlines continuously, biofilm can re-attach and begin growth immediately after shocking your waterlines. Studies have shown that within five days, bacteria counts can grow to...

- a) 200,000 CFU/mL.    b) 200 CFU/mL.    c) 1200,000 CFU/mL.

3. Maxillary lateral incisors are one of the most common teeth to be absent with an incidence of what percentage in Caucasians?

- a) 0.2-0.5%    b) 1-2%    c) 10-12%

## Upcoming CPD Events

As part of UK Dental Specialists committal to dental excellence we periodically organise evening seminars on different dental related subjects. These seminars are free of charge and valid for two CPD hours.

**To register for your place please contact our reception team on 01727 800 372 or email**

**info@UKDentalSpecialists.co.uk** Registration with refreshments starts at 6.30pm and the course begins at 7pm.

Our next available seminars are:

19TH September – Prosthodontics ‘Restoratively driven implant planning’ with Dr Pranay Patel

10th October – Implants ‘Implants: Facts and Fiction’ With Dr Rajiv Patel

## Lunch & Learn

Book a “Lunch & Learn” session. We can visit you or you are welcome to bring your team to us. Let us show you the practice and give you a quick overview of the different treatment options available to your patients. We will provide a light lunch with refreshments. Just let us know how many members of your team will attend and each person will receive training worth 1 CPD hour. A certificate will be issued.

If you would like to participate in these sessions please email [info@UKDentalSpecialists.co.uk](mailto:info@UKDentalSpecialists.co.uk) or call us on 01727 800 372 for more information.



## Private referral form

### Practice and referring dentist details

Referring practice .....

Practice address .....

.....

.....

### Patient details

Patient's name .....

Patient's address .....

Town/City.....Post code: .....

.....

### Treatment required:

Orthodontics

Endodontics

Implants + Restorations

Endodontics + Crown

Implants placement only

Prosthodontics

Periodontics

Oral Surgery

CT Scan

OPG

Reason for referral/provisional diagnosis.....

Treatment carried out to date .....

Medical and dental history .....

.....

Referring dentist details:

Male/female.....

Date of birth .....

Home telephone .....

Mobile .....