PERIODONTAL REFERRAL FORM

Date: __________________________  Time: __________________________

First Name: __________________________  Referred By: __________________________

Last Name: __________________________  Phone: __________________________

REASON FOR REFERRAL

☐ Implants
☐ Gingival Recession
☐ Graft For Root Coverage
☐ Crown Lengthening

☐ Guided Tissue Regeneration
☐ Gingival Contouring For Cosmetics
☐ Ridge Augmentation
☐ Other:

RADIOGRAPHS

☐ Being Mailed
☐ Given to Patient
☐ Please Take
☐ No X-Ray

IMPLANTS

☐ Straumann (ITI)
☐ Nobel Biocare
☐ Zimmer
☐ Thommen (SPI)

☐ Astra
☐ 3i
☐ Neoss

SURGICAL TEMPLATE

☐ Provided by Restorative Dentist

☐ Provided by Periodontist

PERIODONTAL TREATMENT COMPLETED IN YOUR OFFICE

☐ Plaque Control Instruction
☐ Prophylaxis and Gross Scaling

☐ Root Planing
☐ Periodontal Maintenance Therapy

Have you advised the patient of the possibility of extraction of any teeth? If yes, which tooth numbers?

Is there any restorative dentistry that needs to be completed?

COMMENTS:

Thank you for your interest in our services. Please fill out the information above and one of our team members will contact you.