

PERIODONTAL REFERRAL FORM

Patient Name: _____ Phone No: _____
Referring Doctor Name: _____ Phone No: _____
Address: _____

Reason for Referral

- Periodontal Evaluation Only
- Bone Graft
- Implant
- Osseous Surgery
- Crown Lengthening
- Gingivectomy
- Tissue Grafts
- Frenectomy
- Emergency Evaluation (problem focused)
- Other

Tooth #(s) _____ Quads: _____

Has the patient had previous periodontal therapy?

- None
- Prophylaxis Only
- Antimicrobial Therapy
- Scaling and Root Planning
- Surgery

Have you advised the patient of the possibility of extraction of any teeth? Yes No
If yes which teeth? _____

Does the patient require premedication? Yes No

Antibiotic used: _____

Radiographs:

Please take/send copy

Patient will bring copy

I will send / Please return

Your Restorative Plans

Comments: _____

Please

Call me before seeing the patient
Alternate recare appointments

Call me after seeing the patient
Do all recare

General Dentist signature: _____

Date: _____