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 ☐ Call me after seeing the patient
☐ Alternate recare appointments ☐ Do all recare

General Dentist signature: **Date:**