

Periodontics with a Caring Touch



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PATIENT REFERRAL FORM

Date: ____/____/____

Referring Doctor Dr. _____
Telephone _____

This is to introduce: Patient: _____
Telephone: Home _____ Business _____

1. Please evaluate/consult for:

- Generalized Periodontal Disease
- Localized Periodontal Disease (indicate area) _____
- Pre-prosthetic Tx. (i.e., crown lengthening, ridge augmentation): Teeth # _____
- Gingival Graft: Teeth # _____ Frenectomy: Area _____
- Emergency: Area _____ Oral Pathology
- Implants
- Other

Details: _____

2. The patient has been in my practice since _____
Frequency of recalls _____ Last recall date _____

3. Restorative/Other Dental Needs:
 None Wish to discuss along with periodontal treatment plan
 Have Have not discussed and probably include the following:

4. Periodontal treatment (root planing and surgery) to date has included:

5. Specific health concerns are:

Antibiotic prophylaxis required
6. Other referrals: Endo Oral Surgery Ortho M.D.

7. X-rays (date) _____
 FMX Bite Wings P.A. Panorex Not Available
 Enclosed Please Return Keep Copy/Send Back

8. Patient's concerns/motivators/commitment: _____

9. Patient's attitude toward periodontal treatment: _____

10. After your evaluation, please:
 Call me Send a letter Fax a letter Get together to discuss the case Include Perio Charting