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PERIODONTAL REFERRAL FORM

Patient Name:_____ Phone No:_____

Referring Doctor Name:_____

Reason for Referral

Periodontal Evaluation

Recession / Tissue Graft # _____
Bone Graft # _____
Gingivectomy # _____
Hyperpigmentation # _____
Frenectomy # ____Upper ____Lower
____Labial ____Lingual

Emergency Evaluation

Patient has Pain @ _____
Patient has Inflammation @ _____

Restorative Evaluation

Implant Tooth # _____
Crown Lengthening # _____
for Restorative Access
Evaluate Existing Implant # _____

What periodontal care has the patient received or is currently receiving in your office?

- ☐ **None, please evaluate and treat**
- ☐ **Prophylaxis on** _____/_____/_____
- ☐ **Quadrant Scaling and Root Planing on** _____/_____/_____
- ☐ **Antimicrobial Therapy on** _____/_____/_____

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** ☐ **Will email to digitalxr@yahoo.com**

Your Restorative Plans: _____

_____

_____

Comments: _____

_____

_____

Your instructions for periodontist:

- ☐ **Call me BEFORE seeing the patient**
- ☐ **Call me AFTER seeing the patient**
- ☐ **Alternate recare appointments**
- ☐ **Do all recare**
- ☐ **Send me a letter/email after seeing the patient**

General Dentist signature: _____ **Date:** _____