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## PERIODONTAL REFERRAL FORM

Patient Name:______________________________ Phone No:______________________

Referring Doctor Name:______________________________________________

**Reason for Referral (Please fill out with as much information as possible)**

### 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 ____/____/____**

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

________________________________________________

________________________________________________

**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:** ______________