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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 **info@drrobbins.net**

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:** _____