

Referral Form

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Date:

This form is to assist you with patient referrals to periodontal care. Please fill the form carefully and provide as much information about the patient as possible. Before you refer your patient to periodontal consultation/treatment, please check the following:

Patient has been informed about her/his periodontal needs

Oral hygiene is good to excellent

Most recent probing measurements are included

Most recent radiographs are enclosed

Referring dentist: _____ Dr/Mr/Ms _____ is referred to specific _____, comprehensive _____ examination

(specific = crown lengthening, localized areas/problems, recessions etc.)

Patient's address: _____, phone#: _____

Insurance information:

Medical history (medications, allergies, diseases, smoking etc.):

Relevant dental history:

Diagnosis:

Supportive periodontal therapy (scaling and root planing) (when, which areas, frequency etc):

Reason for referral (please indicate the area or tooth#):

crown lengthening

recessions

surgical treatment of localized area

surgical treatment of multiple areas

comprehensive treatment planning

extraction/amputation

preprosthodontic surgery other than crown lengthening

(ridge augmentation, periodontal plastic surgery etc)

other (explain)

Periodontal treatment urgent for comprehensive patient care: yes , no

Other information: