THE PERIODONTISTS

REFERRAL FOR PERIODONTAL / IMPLANT CONSULTATION

Patient name: _____ DOB: _____

Address: _____

_____ Phone: _____

Email: _____

Reason for referral:

- ☐ Assess and treat periodontal condition
- ☐ Aesthetic crown lengthening
- ☐ Restorative crown lengthening
- ☐ Evaluate for soft tissue graft
- ☐ Tooth exposure
- ☐ Frenectomy
- ☐ Biopsy
- ☐ Other: _____
- ☐ Peri-implantitis management
- ☐ Dental Implant consultation
- ☐ Ridge augmentation
- ☐ Sinus floor elevation
- ☐ TAD

Treatment area:

☐ The whole dentition

☐ First quadrant ☐ Second quadrant

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28
48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

☐ Fourth quadrant ☐ Third quadrant

Radiographs included: ☐ BW ☐ PA ☐ OPG ☐ CBCT ☐ Other

Date of radiographs: _____

Relevant medical and dental history: _____

_____

Referred by: _____

Practice Name: _____ Date: _____