Periodontics and Implant Surgery

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Referral form

Patient name _____ Date _____

Telephone _____ Appt. date _____ Time _____

Reason for referral:

- ❍ Complete Periodontal Evaluation
- ❍ Soft tissue graft area(s) _____
- ❍ Dental Implant area(s) _____
- ❍ Extraction and bone grafts area(s) _____
- ❍ Sinus augmentation _____
- ❍ Crown lengthening area(s) _____
- ❍ Laser treatment _____
- ❍ Periodontally accelerated osteogenic orthodontics (PAOO, SFOT) _____
- ❍ All-ON-X _____
- ❍ Biopsy area(s) _____

Area(s) of interest:

1	2	3	4	5	6	7	**8**	**9**	10	11	12	13	14	15	**16**
32	31	30	29	28	27	26	**25**	**24**	23	22	21	20	19	18	**17**

Patient history:

- ❍ Scaling and root planing completed on: _____
- ❍ Patient on a recall every _____ months
- ❍ Other: _____

Radiographs:

❍ FMX dated _____ ❍ BW/PA's dated _____ ❍ CBCT dated _____

❍ Take necessary films

❍ Take CBCT

Comments _____

_____

_____

Referring Doctor _____