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Periodontics with a Caring Touch
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PATIENT REFERRAL FORM

Date: _____/_____/_____

Referring Doctor Dr.____________________
Telephone____________________

This is to introduce: Patient: ____________________
Telephone: Home__________________ Business__________________

1. Please evaluate/consult for:
   - ❑ Generalized Periodontal Disease
   - ❑ Localized Periodontal Disease (indicate area) ________________
   - ❑ Pre-prosthetic Tx. (i.e., crown lengthening, ridge augmentation): Teeth #__________
   - ❑ Gingival Graft: Teeth #______________ ❑ Frenectomy: Area __________
   - ❑ Emergency: Area ______________ ❑ Oral Pathology
   - ❑ Implants
   - ❑ Other

Details:____________________
____

2. The patient has been in my practice since____________________
   Frequency of recalls______________ Last recall date______________
3. Restorative/Other Dental Needs:
   ❑ None ❑ Wish to discuss along with periodontal treatment plan
   ❑ Have ❑ Have not discussed and probably include the following:
   ____
   ____
4. Periodontal treatment (root planing and surgery) to date has included:
   ____
   ____
5. Specific health concerns are:
   ____
   ____
   ❑ Antibiotic prophylaxis required
6. Other referrals: ❑ Endo ❑ Oral Surgery ❑ Ortho ❑ M.D.
7. X-rays (date)____________________
   ❑ FMX ❑ Bite Wings ❑ P.A. ❑ Panorex ❑ Not Available
   ❑ Enclosed ❑ Please Return ❑ Keep ❑ Copy/Send Back
8. Patient's concerns/motivators/commitment:____________________
9. Patient's attitude toward periodontal treatment____________________
10. After your evaluation, please:
    ❑ Call me ❑ Send a letter ❑ Fax a letter ❑ Get together to discuss the case ❑ Include Perio Charting