# Periodontal Referral Form

| Date: mm/dd/yy | / / |
|---|---|
| Time: | |
| Patient's First Name: | |
| Patient's Last Name: | |
| Referred By: | |
| Patient's Telephone: | |

| Complete Periodontal Evaluation |
|---|
| Early |
| Moderate |
| Advanced |

| REASON FOR REFERRAL | RADIOGRAPHS |
|---|---|
| Implants | |
| Gingival Recession | **SURGICAL TEMPLATE** |
| Graft for Root Coverage | |
| Crown Lengthening | |
| Guided Tissue Regeneration | |
| Gingival Contouring for Cosmetics | |
| Ridge Augmentation | |
| Extraction | |
| Other | |

| HAS ANY PERIODONTAL TREATMENT BEEN COMPLETED IN YOUR OFFICE? |
| --- |
| Plaque Control Instruction |
| Prophylaxis and Gross Scaling |
| Root Planning |
| Periodontal Maintenance Therapy |

Have you advised the patient of the possibility of extraction of any teeth? If yes, which tooth numbers:

Tooth #s:

**Please include digital radiograph by pressing the browse button and locating the image on your hard drive:** Please submit form and follow instructions to attach x-ray.

Browse....

Is there any restorative dentistry that needs to be completed?

**COMMENTS**