

PERIODONTAL REFERRAL FORM

1436 Royal York Road, Suite 209, Toronto, Ontario, M9P 3A9
Tel: (416) 243-5215 Fax: (416) 243-0655

Patient Name: _____ **Date:** _____

Patient Telephone #: _____ **Referred by Dr.** _____

Date of Appointment: _____ **Time of Appointment:** _____

Significant Medical History _____

Does this patient require premedication? NO _____ YES _____

Patient is referred for:

- | | |
|--|---|
| <input type="checkbox"/> Emergency Treatment | <input type="checkbox"/> Crown Lengthening |
| <input type="checkbox"/> Facial Pain | <input type="checkbox"/> Cosmetic Perio Treatment |
| <input type="checkbox"/> Specific Perio Treatment | <input type="checkbox"/> Pre-prosthetic Perio Treatment |
| <input type="checkbox"/> Complete Perio Evaluation | <input type="checkbox"/> Dental Implants (s) _____ |
| <input type="checkbox"/> Mucogingival Evaluation | <input type="checkbox"/> Other _____ |

To help us better prepare, the patient:

- | | |
|--|---|
| <input type="checkbox"/> Is a new patient | <input type="checkbox"/> Has had Perio surgery: Date: _____ |
| <input type="checkbox"/> Is an active treatment patient | <input type="checkbox"/> Has had antibiotics: Date: _____ |
| <input type="checkbox"/> Is on recall every _____ months | <input type="checkbox"/> Has case limitations: _____ |
| <input type="checkbox"/> Has had scaling: Date: _____ | _____ |

Available radiographs (Please indicate dates)

All radiographs will be duplicated and returned to your office as soon as possible.

- | | |
|---|--|
| <input type="checkbox"/> Periapicals: No. of films: _____ | <input type="checkbox"/> Are enclosed |
| <input type="checkbox"/> Full mouth series | <input type="checkbox"/> Have been mailed: Date: _____ |
| <input type="checkbox"/> Bitewings | <input type="checkbox"/> We will send |
| <input type="checkbox"/> Panoramic | <input type="checkbox"/> Patient will bring |
| <input type="checkbox"/> Other | <input type="checkbox"/> Return patient to us for x-rays |

Appointment Co-ordination:

- We arranged an appointment with your office
- Please phone patient to arrange an appointment
- Patient will call you to arrange an appointment

Special Comments and/or Considerations: _____

Enclosures: _____ Signature: _____