Referral Form

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Active Member
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I. DATE OF REFERRAL____________________________ REFERRED BY____

PATIENT'S NAME____________________________ DATE OF BIRTH____

TELEPHONE NUMBER__________________________ MEDICAL CONCERNS_______________________________________

ALLERGIES___________________________________ PRE-MED NEEDED____

SCHEDULING: ☐ PATIENT WILL CALL ☐ PLEASE CALL PATIENT

II. **PERIODONTAL REFERRAL**:

___COMPLETE EXAM WITH SPECIAL ATTENTION TO____

___LIMITED EXAM (LIST TEETH NUMBERS)____

___Frenectomy________________ _____Mucogingival Problem________________________

___Crown Lengthening_________ _____Implant____________________________________

___Cuspid Exposure____________ _____Gingivectomy______________________________

HAS SCALING AND ROOT PLANING BEEN COMPLETED?

_______YES DATE______________

_______NO

RADIOGRAPHS:

_______BEING MAILED ___________GIVEN TO PATIENT

_______PLEASE TAKE ___________EMAILED

DO YOU HAVE ANY RESTORATIVE PLANS?____

____

III. **EXTRACTION RECOMMENDATIONS (PLEASE CIRCLE TEETH TO BE REMOVED)**

1 2 3 4 5 6 7 8 A B C D E **R**	9 10 11 12 13 14 15 16 F G H I J **L**
T S R Q P 32 31 30 29 28 27 26 25	O N M L K 24 23 22 21 20 19 18 17

IV. **IMPLANT REFERRAL:**

PLEASE LIST YOUR DESIRED IMPLANT POSITION(S):

____

DO YOU HAVE A SURGICAL TEMPLATE? _____________YES ______________NO

IS AN INTERIM PROSTHESIS MADE

____NO _______YES WHAT TYPE?____

DO YOU HAVE A SPECIFIC IMPLANT YOU WISH TO BE PLACED?

ITI (STRAUMANN)___________________________

BIOHORIZONS______________________________

IMTEC (MINIS)_______________________________

OTHER_______________________________________

V. **OTHER PROCEDURES**

____BIOPSY _______I & D ______RIDGE AUGMENTATION

____ALVEOLOPLASTY _______SINUS AUGMENTATION

____OTHER____