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DAG

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PATIENT REFERRAL FORM

I have the pleasure of referring:

_____

to your office for:

- ☐ A full mouth periodontal evaluation and treatment
- ☐ Scaling and root planing
- ☐ Occlusal evaluation and treatment
- ☐ Splint therapy
- ☐ Plaque culture and sensitivity
- ☐ TMD evaluation
- ☐ Recall
- ☐ Preprosthetic consultation
- ☐ Extraction of tooth/teeth #s _____
- ☐ Periodontal osseous surgery:
  - ☐ Flap procedure in the _____ area
  - ☐ Osseous regenerative procedure in the _____ area (GBR)
  - ☐ Crown lengthen – tooth #s _____
- ☐ Mucogingival surgery:
  - ☐ Add keratinized tissue in the _____ area
  - ☐ Root coverage around teeth #s _____
- ☐ Ridge augmentation in the _____ area
  - ☐ With extraction of teeth #s _____
- ☐ Orthodontic/periodontic surgery:
  - ☐ Frenectomy ☐ Fiborotomy ☐ Tooth exposure: tooth # _____
- ☐ Implants in the _____ area
  - ☐ Site preparation for implant _____
  - ☐ Implant repair _____
- ☐ Biopsy ☐ H&E ☐ Immunoflourescent ☐ Brush
- ☐ Previous periodontal therapy included:
  - ☐ Scaling ☐ Surgery Date: _____
- ☐ Radiographs:
  - ☐ Will send ☐ Patient carrying ☐ Enclosed ☐ Please take a new duplicate series

Please call me. A convenient time is _____

Referring Doctor _____