PERIODONTAL REFERRAL FORM

1436 Royal York Road, Suite 209, Toronto, Ontario, M9P 3A9
Tel: (416) 243-5212 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:

____ Emergency Treatment
____ Facial Pain
____ Specific Perio Treatment
____ Complete Perio Evaluation
____ Mucogingival Evaluation
____ Crown Lengthening
____ Cosmetic Perio Treatment
____ Pre-prosthetic Perio Treatment
____ Dental Implants (s) __________________________
____ Other _______________________________________

To help us better prepare, the patient:

_____ Is a new patient
_____ Is an active treatment patient
_____ Is on recall every ____ months
_____ Has had scaling: Date: ___________
_____ Has had Perio surgery: Date: ____________
_____ Has had antibiotics: Date:
_____ Has case limitations: _________________________
____

Available radiographs (Please indicate dates)
All radiographs will be duplicated and returned to your office as soon as possible.

_____ Periapicals: No. of films: ________
_____ Full mouth series
_____ Bitewings
_____ Panoramic
_____ Other
_____ Are enclosed
_____ Have been mailed: Date: ____________
_____ We will send
_____ Patient will bring
_____ 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: ____

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Enclosures: _____________________________________ Signature: ______________________________