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# PERIODONTAL REFERRAL

**DOCTOR:** ______________________________

**PATIENT:** ______________________________ **DATE:** ________________

PATIENT HAS HAD:
PLAQUE CONTROL ☐ SCALING ☐ RECENT FULL MOUTYH X-RAYS ☐

TIME IN PRACTICE: YEARS_______ NEW ☐ ACTIVE RECALL YES NO

MAY ALSO REQUIRE ENDODONTICS ☐ ORAL SURGERY ☐ ORTHODONTICS ☐

PATIENT'S DENTAL HEALTH: GOOD ☐ FAIR ☐ NEEDS TO BE MOTIVATED ☐

PATIENT'S CONCERNS: ESTHETICS ☐ DISCOMFORT ☐ TOOTH LOSS ☐
APPREHENSION ☐ TIME LOSS ☐ OTHER ☐

**REFERAL FOR:**
GENERALIZED PROBLEM: ______________________________
______________________________
______________________________

SPECIFIC PROBLEM:

☐ CROWN LENGHTENING TOOTH #____________
WILL THE TOOTH BE RESTORED FOLLOWING THE CROWN LENGHTENING? YES NO

☐ RIDGE AUGMENTATION WHAT TYPE OF PROVISION IS PLANNED: FIXED ______ REMOVABLE ______
IS AN OVATE PANTIE PLANNED? YES NO
WILL AN IMPLANT BE PLACED IN THIS AREA? YES NO

☐ SOFT TISSUE GRAFT TOOTH # ______________
IS THE ROOT COVERAGE DESIRED? YES NO
WILL THESE TEETH BE RESTORED? YES NO
WILL THERE BE INTRACREVICULAR MARGINS ON THESE TEETH? YES NO

☐ IMPLANTS- LOCATION(S):______________________________

PROSTHETIC CONSIDERATIONS: ________________________

SPECIAL COMMENTS: ______________________________
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