PETERBOROUGH PERIODONTICS

Periodontal & Implant Surgery

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Patient Referral

Referring Doctor: _____ **Date:** _____

Address: _____ Phone: _____

Patient Information:

Name: _____ Birthdate: _____

Address: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Reason for Referral: ☐ Consultation Only ☐ Consultation & Treatment

☐ Complete Periodontal Assessment ☐ Implant Consultation ☐ Specific Problem

Notes: _____

	8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8	
Right																	Left
	8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8	

Therapy Required:

☐ Pocket Depth Reduction
☐ Mucogingival Augmentation
☐ Regenerative Procedure
☐ Implant Surgery
☐ Other: _____

☐ Crown Lengthening
☐ Sinus Lifting
☐ Oral Lesion Assessment
☐ Biopsy

Appointment Details:

☐ We have scheduled the following appointment:

Appointment Date: _____ Time: _____

☐ Patient will call to schedule appointment

☐ Please contact patient to schedule appointment

Enclosures: ☐ original x-rays ☐ duplicated x-rays ☐ emailed ☐ other

Specific Comments: _____

_____

_____

_____