



Periodontic Referral

Specialist Name: _____ Phone Number: _____
 Address: _____ FAX Number: _____
 _____ Appointment Date: _____
 Patient Name: _____ Appointment Time: _____
 Referring Doctor: _____ Phone Number: _____

CALL REFERRING DOCTOR BEFORE TREATMENT: YES / NO

Symptoms:

- PAIN
- Pockets
- Recession
- Bleeding
- Other: _____
- Acute periodontal abscess
- Mobility
- Inadequate attached gingiva
- Bone loss

TEETH IN QUESTION:

R	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	L
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

Referred For:

- Complete Periodontal Examination and Treatment
- Limited Periodontal Evaluation and Treatment
- Implant Examination
- Single Tooth Replacement
- Implant Supported Fixed Partial Denture
- Other _____
- Crown Lengthening
- Bone Regeneration (GBR)
- Periodontal Plastic Surgery
- Soft Tissue Graft
- Implant Supported Overdenture

Scaling & Root Planing:

Completed (Date: _____)

Recent FMX or PA's

- Being sent _____
- Please take _____

 Doctor Signature

 Date

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INSTRUCTIONS

Complete and sign the referral form. Then send to the doctor via one of the following options:

1. Email: Fill out the form. Print.
 - Scan the completed form and save as a JPEG or PDF file.
 - Open your email client and attach the saved (scanned) document.
 - Send to the Office Email address.
2. Print the form. Then, Fax it to the doctor's office (fax number on page 1 of this form or on the DSI website).
3. Print the form. Then, Mail it to the doctor's office (address on page 1 of this form or on the DSI website).
4. Print the form. Give to the patient to deliver to the doctor's office.