

## REFERRAL REQUEST

REFERRING DOCTOR \_\_\_\_\_

DATE \_\_\_\_\_

MR/MRS/MS/DR \_\_\_\_\_

HOME PH \_\_\_\_\_

is being referred to you for periodontal examination,

WORK PH \_\_\_\_\_

### The following condition(s) are of concern

- Generalized periodontitis \_\_\_\_\_
- Localized periodontitis (teeth) \_\_\_\_\_
- Mucogingival defect, recession (teeth) \_\_\_\_\_
- Crown lengthening (teeth) \_\_\_\_\_
- Edentulous ridge augmentation (area) \_\_\_\_\_
- Extractions and ridge augmentation \_\_\_\_\_
- Endosseous Implant \_\_\_\_\_
- Other condition \_\_\_\_\_
- Tentative Restoration Plan \_\_\_\_\_

### Radiographs

- Full Mouth radiographs are being sent with patient.
- Full mouth radiographs are being mailed.
- Please copy x-rays and return originals to me.
- Other radiographs are being sent. (Specify) \_\_\_\_\_

Comments \_\_\_\_\_

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