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Referral Form

Patient's Name: Cell #:
Contact (If patient is a minor): Home #:
Courtesy of Dr: Work #:
Date of Referral: Patient's email:

Tooth Number(s)/ Quad(s):

Reason For Referral: (CHECK ALL THAT APPLY):

- Consultation, Periodontal Disease Evaluation, Pocket Reduction Surgery / LANAP, Crown Lengthening, Frenectomy, Surgical Uncovering for Orthodontics, Distal Wedge Surgery, Guided Tissue Regeneration (GTR) for vertical bony defect.
Gingival Recession, Soft Tissue Graft; thin/no attached tissue, Anterior Esthetic Crown Lengthening, Soft Tissue Biopsy, Extraction, Extraction / Bone Grafting, Extraction / Immediate Implant Placement
Implant Placement, Implant for Overdenture, Ridge Augmentation, Sinus Graft, IV Sedation, Other:

Restorative Implications:

Restorative Implications: (blank lines for text)

Treatment Completed, if any (eg. SRP's):

Treatment Completed, if any (eg. SRP's): (blank lines for text)

Referring Doctor's Comments and Special Instructions (Preferred Implant type, e.g., ASTRA, STRAUMANN, etc...):

Referring Doctor's Comments and Special Instructions (Preferred Implant type, e.g., ASTRA, STRAUMANN, etc...): (blank lines for text)

Enclosed Records: Perio charting, FMX, Periapical, Pano, Referral Form, Given to Patient

Please call:

Before Patient Consult

After Consult

No Call Necessary

