REFERRAL FOR PERIODONTAL EVALUATION

PERIOWEST

REFERRED BY

Doctor _____ Date _____

Phone _____ Fax _____

INTRODUCING MY PATIENT

Name _____

Email _____ DOB _____

Home Phone _____ Work _____ Cell _____

Medical Alerts / Allergies / Concerns _____

_____

Radiographs ☐ Mailed ☐ Emailed

REASON FOR REFERRAL

☐ DENTAL IMPLANT CONSULT

Proposed Site(s) _____

☐ COMPREHENSIVE PERIODONTAL EXAM

☐ SPECIFIC PERIODONTAL EXAM

☐ ____ Ridge Augmentation ☐ ____ Recession/Keratinized Tissue

☐ ____ Crown Lengthening ☐ ____ Sinus Augmentation

☐ ____ Aesthetic Gingival Grafting ☐ ____ Unerupted Tooth Exposure

☐ Other _____

COMMENTS

Restorative Plan / Additional Notes _____

_____

_____

Thank you for the confidence of your referral.

DR. PRISCILLA WALSH
Certified Specialist in Periodontics
Dental Implant Surgery

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