WORCESTER
PERIODONTICS

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PATIENT REFERRAL FORM

Diplomate of the American Board of Periodontology

PRACTICE LIMITED TO PERIODONTICS WITH SERVICES IN DENTAL IMPLANTS, ORAL MEDICINE, AND LASER SURGERY

Please take a moment and complete this form, indicating where we may be of service and assistance to both you and your patient.

Patient: ______________________________

Referring Doctor: ______________________________

Phone: ______________________________

How may we assist your patient and you in the treatment of your patient?

Please examine treatment plan completely and comprehensively

- ❑ Bone loss and/or periodontal pocketing and/or furcation involvement __________
- ❑ Gingival recession and/or mucogingival problems __________
- ❑ Crown lengthening may be necessary (teeth #__________)
- ❑ Guided tissue regeneration may be necessary __________
- ❑ Consultation for dental implants (teeth # __________)
- ❑ Observed gingival inflammation __________
- ❑ Observed oral pathology __________
- ❑ Extraction (teeth#________) Reason __________

Models (Diagnostic casts)

- ❑ Available ❑ Unavailable
- ❑ Send by mail __________ Brought by patient __________
- ❑ Please call our office
- ❑ FMX will be supplied via mail/email (CIRCLE ONE)
- ❑ FMX unavailable — please take
- ❑ FMX will be brought to consultation by patient
- ❑ Patients has been in my practice for__________ years Or patient is new__________

Prosthetic/restorative plans, comments, concerns, case description

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