

Periodontal & Dental Implant Referral Form

REFERRING PRACTITIONER:

NAME: _____

ADDRESS: _____

POSTCODE: _____

TEL: _____ FAX: _____

MOBILE: _____ EMAIL: _____

PATIENT DETAILS:

DOES THE PATIENT HAVE PRIVATE HEALTH INSURANCE (PLEASE TICK) YES NO

SURNAME: _____ FORENAMES: _____

TITLE: _____ DATE OF BIRTH: _____

ADDRESS: _____

POSTCODE: _____

TEL (HOME): _____ TEL (WORK): _____

MOBILE: _____ EMAIL: _____

ORAL HEALTH STATUS (PLEASE TICK):

ORAL HYGIENE: GOOD FAIR POOR

SOFT TISSUE: NORMAL ABNORMAL

REFERRAL REQUIREMENTS (PLEASE TICK):

<input type="checkbox"/> PERIODONTAL ASSESSMENT	<input type="checkbox"/> MUCO - GINGIVAL SURGERY	<input type="checkbox"/> GUIDED BONE REGENERATION (BONE GRAFTING)
<input type="checkbox"/> PERIODONTAL TREATMENT	<input type="checkbox"/> CROWN LENGTHENING	<input type="checkbox"/> GINGIVAL RECESSION
<input type="checkbox"/> IMPLANTOLOGY	<input type="checkbox"/> EXTRACTION / ORAL SURGERY	<input type="checkbox"/> OTHER

ENCLOSURES (PLEASE TICK):

<input type="checkbox"/> PATIENT RECORDS	<input type="checkbox"/> STUDY MODELS	<input type="checkbox"/> PHOTOGRAPHS
<input type="checkbox"/> X-RAYS	<input type="checkbox"/> OTHER	

PATIENT MEDICAL HISTORY:

COMMENTS:

PRACTITIONERS SIGNATURE: _____ DATE: _____