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PERIODONTAL REFERRAL

Patient Name_____

Teeth Number(s) _____

- Comprehensive periodontal evaluation
- Specific periodontal evaluation
- Perio pockets that had not responded to SRP. Last SRP date_____
- Gingival recessions_____
- Root coverage _____
- Gummy smile Correction
- Crown Lengthening
- Frenectomy
- Bone graft/ GTR
- Ortho exposure _____
- Implant consult_____
- Intraoral Lesion _____

Notes: _____

_____

_____

X-rays Emailed: _____ Date Taken: _____

Referring Provider: _____

Email: _____ Phone: _____