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Referral Information

Patient:________________________________ Date:______________________

I am referring this patient for:

- Complete Periodontal Evaluation and Treatment
- Isolated Periodontal Evaluation and Treatment
- Crown Lengthening Procedure
- Recession and Grafting
- Ridge Augmentation
- GTR and Bone Grafting
- Implant Consultation
- Other:____

Radiographs:

- Last Full series Taken:________ FMX___ PA____ Other____
- Are accompanying patient
- Mailed
- E-mailed

Last Scaling/Root Planing Completed In Your Office?________

Pre-Medication or Special Medical Consideration

- Yes______ No______
- If yes, explain:____

Any other Comments?____

Referring Doctor:________________________ Phone number:_________________