Referral Form for Syed Khalid D.D.S., M.S.
Practice Limited to Periodontics and Implant Dentistry
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Active Member
American Academy of Periodontology

I. DATE OF REFERRAL_____ REFERRED BY_____

PATIENT'S NAME_____ DATE OF BIRTH_____

TELEPHONE NUMBER_____ MEDICAL CONCERNS_____

ALLERGIES_____ PRE-MED NEEDED_____

DOES THE PATIENT TAKE A BLOOD THINNER? _____ YES _____ NO

SCHEDULING: ☐ PATIENT WILL CALL ☐ PLEASE CALL PATIENT AT PHONE #_____

II. **PERIODONTAL REFERRAL**:

_____COMPLETE EXAM WITH SPECIAL ATTENTION TO_____

_____LIMITED EXAM (LIST TEETH NUMBERS)_____

_____Frenectomy_____ _____Mucogingival Problem_____

_____Crown Lengthening_____ _____Implant_____

_____Cuspid Exposure_____ _____Gingivectomy_____

HAS SCALING AND ROOT PLANING BEEN COMPLETED?

_____YES DATE_____

_____NO

RADIOGRAPHS:

_____BEING MAILED _____GIVEN TO PATIENT

_____PLEASE TAKE _____EMAILED

DO YOU HAVE ANY RESTORATIVE PLANS?_____

III. **EXTRACTION RECOMMENDATIONS (PLEASE CIRCLE TEETH TO BE REMOVED)**

1 2 3 4 5 6 7 8 A B C D E **R**	9 10 11 12 13 14 15 16 F G H I J **L**
T S R Q P 32 31 30 29 28 27 26 25	O N M L K 24 23 22 21 20 19 18 17

IV. **IMPLANT REFERRAL:**

PLEASE LIST YOUR DESIRED IMPLANT POSITION(S): _____

DO YOU HAVE A SURGICAL TEMPLATE? _____YES _____NO

IS AN INTERIUM PROSTHESIS MADE? _____NO _____YES WHAT TYPE? _____

DO YOU HAVE A SPECIFIC IMPLANT YOU WISH TO BE PLACED?

BIOHORIZONS_____

ITI (STRAUMANN)_____

OTHER_____

V. **OTHER PROCEDURES**

_____BIOPSY _____I & D _____RIDGE AUGMENTATION

_____ALVEOLOPLASTY _____SINUS AUGMENTATION _____ALL ON FOUR PROCEDURE

_____OTHER_____