

Referral Form

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DATE OF REFERRAL	REFERRED BY
	DATE OF BIRTH
TELEPHONE NUMBER	MEDICAL CONCERNS
ALLERGIES	PRE-MED NEEDED
DOES THE PATIENT TAKE A BLOOD THINNER?	YESNO
SCHEDULING: PATIENT WILL CALL	PLEASE CALL PATIENT AT PHONE #
PERIODONTAL REFERRAL:	A TTENTION TO
LIMITED EXAM (LIST TEETH NUM	ATTENTION TO
Frenectomy	MBERS)Mucogingival Problem ImplantGingivectomy
Crown Lengthening	Implant
Cuspid Exposure HAS SCALING AND ROOT PLANING BE	Gingivectomy EN COMPLETED?
YES DATEYES	
NO	
RADIOGRAPHS:	CHAINA TO DA THEAT
BEING MAILED DIEASE TAVE	GIVEN TO PATIENTEMAILED
DO YOU HAVE ANY RESTORATIVE PLA	ANS?
EXTRACTION RECOMMENDATIONS (PLEAS	·
1 2 3 4 5 6 7 8	9 10 11 12 13 14 15 16
A B C D E	F G H I J
R	L
T S R Q P	O N M L K 24 23 22 21 20 19 18 17
32 31 30 29 28 27 26 25	24 23 22 21 20 19 18 17
IMPLANT REFERRAL:	
PLEASE LIST YOUR DESIRED IMPLANT POS	SITION(S):
DO YOU HAVE A SURGICAL TEMPLATE?	YESNO
IS AN INTERIUM PROSTHESIS MADE?	NOYES WHAT TYPE?
DO YOU HAVE A SPECIFIC IMPLANT YOU V	WISH TO BE PLACED?
BIOHORIZONS	
ITI (STRAUMANN)	
OTHER	
OTHER PROCEDURES	
BIOPSY I & D	RIDGE AUGMENTATION
	UGMENTATIONALL ON FOUR PROCEDURE
OTHER	