

Referral Form



Syed Khalid D.D.S., M.S. & Lidya Jirjis, D.D.S., M.S.
Practice Limited to Periodontics and Implant Dentistry
4450 Baytown Central Blvd., Baytown, Texas 77521
281-427-5118 - 281-428-8529 (fax)
info@baytownperiodontics.com
www.baytownperiodontics.com



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 _____