

PERIODONTICS NORTHWEST

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Date: _____

Introducing: _____

Address _____

City _____

Telephone _____

(Residence)

(Business)

Referred By: _____

Reason for Referral: _____

- | | |
|--|---|
| <input type="checkbox"/> Complete Periodontal Exam | <input type="checkbox"/> Restorative Consultation |
| <input type="checkbox"/> Limited Periodontal Exam | <input type="checkbox"/> Emergency |
| <input type="checkbox"/> Mucogingival Problem | <input type="checkbox"/> Other (specify) _____ |
| <input type="checkbox"/> Crown Lengthening | <input type="checkbox"/> Implants |
| <input type="checkbox"/> Oral Pathology | |

Comments: _____

Radiographs:

- Are needed. And remit copy.
- Are enclosed. Please return after treatment.
- Accompanying patient.
- Please coordinate X-rays for implant exam.

Appointment:

- An appointment has been scheduled for _____ at _____
- Please contact our patient and schedule an appointment.
 - Our patient was advised to call your office for an appointment. If the patient does not call within 2 weeks, please contact them to schedule an appointment.

Treatment provided by our office:

- Long term maintenance patient New patient to our office
- Prophy performed: Date: _____
- SRP performed: Date: _____

Treatment Coordination:

- The following treatment has been presented to my patient.
Please reinforce. _____
- Please telephone my office prior to your examination.
- I would like to do my own:
Extractions _____ Endo _____ SRP _____
Bite Adjustment _____ Orth _____

Pink Copy: Retain for your records. Yellow Copy: Send to Periodontics NW
Thank you for your kind referral!