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Board-Certified Periodontal Plastic Surgery And Surgical Implantology

Referral Form

Date: ____ / ____ / ____

Introducing: _____

DOB: _____

☐ Patient will contact you -OR- Please CONTACT PATIENT: Phone #: _____

Email: _____

➤ REASON FOR REFERRAL:

- ☐ Extraction / Ridge Preservation
- ☐ Implant Site Preparation: Ridge Augmentation / Sinus Lift
- ☐ Dental Implants
- ☐ All-on-X – Maxilla / Mandible

- ☐ Recession / Soft Tissue Graft
- ☐ Crown Lengthening – Functional / Esthetic
- ☐ Frenectomy
- ☐ Biopsy

☐ Other: _____

➤ CHIEF AREA OF CONCERN:

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

➤ RADIOGRAPHS:

- ☐ Emailing all radiographs (including CBCT), perio charting, and other info available (ie- notes, photos) from my office to: referrals@PerioSurgicalArts.com
- ☐ Radiographs sent with patient
- ☐ Mailing Radiographs
- ☐ No radiographs, please take what is needed

REFERRED TO: ☐ First Available ☐ Dr. Joelle McRee ☐ Dr. Nicole Litizzette ☐ Dr. David Yu

COMMENTS:

Signed: Dr. _____

Please print name: Dr. _____

Phone: _____