AUSTIN PERIO HEALTH

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PERIODONTAL REFERRAL INFORMATION

Date: _____

Patient's Name: _____

Reason for Referral:
- ☐ Full/Local Periodontal Evaluation
- ☐ Periodontitis: Moderate/Severe Generalized/Localized
- ☐ Crown Lengthening # _____
- ☐ Frenectomy # _____
- ☐ Recession/Graft Evaluation # _____
- ☐ Bone Graft/Guided Tissue Regeneration
- ☐ Implant Evaluation # _____
- ☐ Other _____

Available X-rays:
- ☐ BW only
- ☐ FMX Date Taken _____
- ☐ Select PA's _____
- ☐ None

Our office has performed:
- ☐ Exam only
- ☐ Initial Cleaning
- ☐ Scaling and Root Planing Dates Performed _____
- ☐ Comments: _____

Referred by: _____