

PERIODONTAL & IMPLANT REFERRAL

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WE ARE REFERRING:

DATE: _____

Patient: _____ **D.O.B.:** MM / DD / YY

Address: _____ **Postal Code:** _____

Telephone / Home: _____ **Cell:** _____ **Business:** _____

Significant Medical History Findings: _____

REASONS FOR REFERRAL:

- | | |
|--|---|
| <input type="checkbox"/> Full Mouth Periodontal Evaluation | <input type="checkbox"/> Localized Evaluation # (s) _____ |
| <input type="checkbox"/> Esthetic Evaluation Area: _____ | <input type="checkbox"/> Crown Lengthening # (s) _____ |
| <input type="checkbox"/> Ridge Augmentation Area: _____ | <input type="checkbox"/> Soft Tissue Grafting # (s) _____ |
| <input type="checkbox"/> Implant Evaluation Area: _____ | |

REMARKS OR SPECIAL INSTRUCTIONS _____

PERIODONTAL TREATMENT COMPLETED TO DATE

- Scaling Root Planing Surgery Type: _____

- | | |
|--|--|
| RADIOGRAPHS: <input type="checkbox"/> Sending radiographs | PERIODONTAL PROBINGS: <input type="checkbox"/> Sending probings |
| <input type="checkbox"/> No recent radiographs | <input type="checkbox"/> No recent probings |

INSURANCE INFORMATION:

Insurance Co.: _____ **I.D.#:** _____

Employer: _____ **Group #:** _____

Note: we do not take assignment for insurance, however, we will assist you in filling out your insurance form(s)

REFERRING DENTIST: _____ **Signature** _____

REFERRING HYGIENIST: _____