

PATIENT'S NAME _____ **REFERRING DR.** _____

APPOINTMENT DATE & TIME: _____ **TODAY'S DATE:** _____

REASON FOR REFERRAL AND CONCERN:

- Complete periodontal evaluation: _____
- Implant evaluation; tooth no(s). or area(s): _____
- Recession/inadequate attached gingiva/soft tissue grafting; tooth no(s). _____
- Functional crown lengthening, tooth no(s). _____
- Esthetic crown lengthening/gingival contouring; tooth no(s). _____
- Ridge augmentation to enhance esthetics in pontic area; area(s) _____
- Other _____

TENTATIVE RESTORATIVE TREATMENT PLAN:

- Restorative consultation desired after periodontal consultation
- Restorative already completed
- Minor restorations only

PRIMARY RESTORATIVE TREATMENT PLAN:

SECONDARY RESTORATIVE TREATMENT PLAN:

DOCTOR'S CONCERNS:

PATIENT'S CONCERNS/FEARS/MOTIVATORS:

X-RAYS:

- Full mouth series taken within last year enclosed
- Take necessary x-rays and send duplicate set for my records
- Bitewings enclosed
- Pano enclosed
- Please return x-rays
- You may keep the x-rays for your records
- X-rays being sent via email

CORRESPONDENCE:

- Send correspondence via email to referring dentist

Please retain the Yellow copy for your records.