PERIO REFERRAL

GTA NORTH

PERIODONTICS & ENDODONTICS

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DATE: _____ PATIENT TEL: _____

INTRODUCING: _____

REASON FOR REFERRAL

- ☐ CONSULT & TREATMENT
- ☐ DEEP PERIODONTAL POCKETS
- ☐ TREATMENT PLANNING
- ☐ BIOPSY/ASSESS LESION
- ☐ SECOND OPINION
- ☐ CROWN LENGTHENING
- ☐ FRENECTOMY
- ☐ GINGIVAL RECESSION/GRAFT
- ☐ EMERGENCY

CONE BEAM CT Scan

☐ LOCATION (circle below) MEASUREMENTS ☐ YES ☐ NO (INDICATE REASON FOR SCAN BELOW)

8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8
8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8

DENTAL IMPLANT CONSULTATION

- ☐ EXTRACTION & SOCKET GRAFTING
- ☐ RIDGE AUGMENTATION
- ☐ SINUS LIFT
- ☐ SINGLE TOOTH
- ☐ MULTIPLE TEETH
- ☐ FULL ARCH

ORTHODONTIC CO-THERAPY

☐ TOOTH EXPOSURE ☐ TAD PLACEMENT

RADIOGRAPHS

☐ ENCLOSED ☐ WILL SEND VIA E-MAIL ☐ WITH PATIENT ☐ NONE AVAILABLE

REMARKS: _____

_____

REFERRING DR. _____

☐ TEL: _____ ☐ EMAIL: _____

PLEASE INDICATE YOUR PREFERRED METHOD OF CONTACT

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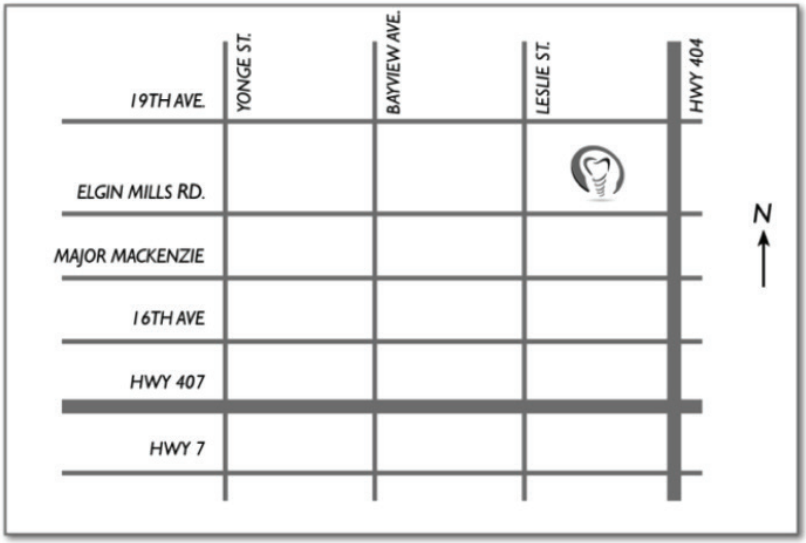

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