REFERRAL FOR
PERIODONTAL EVALUATION

REFERRED BY

Doctor ______________________ Date ______________

Phone ______________________ Fax ______________

INTRODUCING MY PATIENT

Name ______________________

Email ______________________ DOB ______________

Home Phone ______________ Work ______________ Cell ______________

Medical Alerts / Allergies / Concerns ______________________

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Radiographs ☐ Mailed ☐ Emailed

REASON FOR REFERRAL

- ☐ COMPREHENSIVE PERIODONTAL EXAM
- ☐ DENTAL IMPLANT CONSULT
- ☐ MUCOGINGIVAL CONCERNS/GINGIVAL RECESSION
- ☐ CROWN LENGTHENING
- ☐ UNERUPTED TOOTH EXPOSURE
- ☐ AUTOTRANSPLANTATION
- ☐ OTHER

COMMENTS

Restorative Plan / Additional Notes ______________________

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Thank you for the confidence of your referral.

DR. PRISCILLA WALSH
Certified Specialist in Periodontics
Dental Implant Surgery

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