FAX REFERRAL

To:_____

From:_____

Date: Pages: (including cover sheet)

Patient Name: _____ Phone:_____

Referred By Dr: _____

Pertinent Medical History (ie: Antibiotic PreMed):_____

Please Evaluate:

____ General Periodontal Condition
(Comprehensive Exam-FMX required)

____ Isolated Area (Teeth #;s ____)
(Limited Exam-PA required 1-3 teeth only)

____Cat Scan
- □ Implant Series: Tooth #_____
- □ TMJ Series
- □ Sinus Series
- □ Report Requested By Date_____

- □ Frenectomy/Soft Tissue Graft
- □ Implant Evaluation
  - □ Our office will provide stent
- □ Mucogingival Involvement
- □ Crown Lengthening Procedure
- □ Periodontal Abcess

Radiographs:

- □ Enclosed please find all radiographs available from my office.
- □ I have no radiographs, please take what you need.
- □ Our office will forward x-rays.

Tentative Restorative Treatment Plans:

_____

_____

Comments:

_____

_____

- □ Please complete all Phase I – (Initial Prep) at *your* office. (Scale/Root plane)
- □ Please refer patient back to *our* office for Phase I completion.

Signed:

Munib Derhalli, D.M.D, M.B.A., M.S.

Diplomate of the American Board of Periodontology
Practice limited to Periodontics and Implants

Cascade Park
300 SE 120th Ave., Ste 500, Vancouver, WA 98683 360-254-8151 Fax: 360-254-7175

Email: ptreferrals@periodontalconcepts.net