

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)

- Frenectomy/Soft Tissue Graft
- Implant Evaluation
- Our office will provide stent

_____ Cat Scan

- Implant Series: Tooth # _____
- TMJ Series
- Sinus Series
- Report Requested By Date _____

- Mucogingival Involvement
- Crown Lengthening Procedure
- Periodontal Abscess

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

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