CROYDON DENTAL
EXCELLENCE IS OUR PASSION
YOUR TRUST IS OUR PRIDE

PERIODONTIST REFERRAL FORM

PATIENT INFORMATION

Patient _____

DOB _____ Phone _____

Email _____

Address _____

REFERRING DENTIST

Dentist _____

Clinic _____

Phone / Email _____

Date of referral _____

REASON FOR REFERRAL (check all that apply)

- ☐ Comprehensive periodontal assessment
- ☐ Implant consultation / placement
- ☐ Periodontal surgery / regeneration
- ☐ Periodontal disease / pocketing
- ☐ Bone graft / ridge augmentation
- ☐ Peri-implantitis
- ☐ Recession / soft-tissue graft
- ☐ Crown lengthening
- ☐ Other _____

TEETH / AREA OF CONCERN _____

CLINICAL INFORMATION

Provisional diagnosis / findings _____

Probing depths / BOP / mobility / furcation / recession _____

Relevant radiographic findings _____

Medical considerations (e.g., diabetes, smoking, medications, allergies) _____

RECORDS ENCLOSED

☐ Radiographs / CBCT ☐ Periodontal charting ☐ Clinical photos ☐ Medical history ☐ Other _____

Referring dentist signature _____ Date _____

Please return consultation findings and recommendations to the referring dentist.

