



PERIODONTIST REFERRAL FORM

PATIENT INFORMATION	REFERRING DENTIST
Patient: _____	Dentist: _____
DOB: _____ Phone: _____	Clinic: _____
Email: _____	Phone / Email: _____
Address: _____	Date of referral: _____

REASON FOR REFERRAL (check all that apply)

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

REQUESTED CARE / PRIORITY

☐ Consultation only ☐ Assessment and treatment recommendations ☐ Please provide treatment (if appropriate)
Priority: ☐ Routine ☐ Urgent — reason: _____
Specific questions / treatment requested: _____

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.