44 | THE PRIVATE DENTAL CENTRE

PERIODONTAL REFERRAL FORM

www.44derngate.co.uk

REFERRING DENTIST

Name:

Practice:

Address:

Postcode:

Phone:

Fax:

Mobile:

E-mail:

PATIENT DETAILS

Name:

Practice:

Address:

Postcode:

Phone:

Fax:

Mobile:

E-mail:

I wish to refer the above patient for a private consultation and treatment regarding:

- Generalised Periodontal Disease
- Periodontal Destruction Particularly Associated with

BPE

Please tick as appropriate

8 7 6 5 4 3 2 1 1 2 3 4 5 6 7 8

8 7 6 5 4 3 2 1 1 2 3 4 5 6 7 8

Referral details

Purpose of referral:

Patients main complaint:

HISTORY

Urgent referrals should be clearly marked and given priority

We can assist with

- Treatment of Gingivitis
- Treatment of Periodontal disease
- Gum disease treatment around implants - Peri-implantitis
- Correction of uneven gum line (crown lengthening)
- Cosmetic gum graft to correct gum shrinkage
- Treatment of halitosis

Access to patient results: Results of investigations are included within patient letters.

Documents	Enclosed	In the post	To return?
Patient records			
Consent form			
Study models			
Radiographs			
Intra-oral:			
Panoral:			
Dental history			

Other relevant information:

Signature:

Date: