

periodontal referral form

Practice Details

Referring Dentist: _____ Date Referred: _____

Referring Practice: _____

Patient Details

Mr Mrs Ms Miss Other Patient's Name: _____

Patient's Address _____

Telephone Numbers: Home: _____ Work: _____ Mobile: _____

Email: _____

Date of Birth: _____ Is this referral urgent? Yes No

Reason for Referral (please cross all relevant boxes)

- | | |
|--|---|
| <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Crown lengthening |
| <input type="checkbox"/> Surgical periodontal treatment | <input type="checkbox"/> Soft-tissue surgery |
| <input type="checkbox"/> Other reason (please specify below) | <input type="checkbox"/> Guided tissue regeneration |

Brief History / Comments About This Referral

Investigations (already carried out)

BPE Score _____ DPT Bitewings Periapical Are these enclosed? _____

Has the patient been informed of the cost of the consultation/treatment? Yes No

Has the patient been informed on the location of LHDP Referral Centre Yes No