LHDP SMILECARE
IMPLANT AND REFERRAL CENTRE

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www. lhdpsmilecare. co.uk

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)

☐ Periodontal treatment
☐ Surgical periodontal treatment
☐ Other reason (please specify below)
☐ Crown lengthening
☐ Soft-tissue surgery
☐ 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

If you require more periodontal referral forms please tick this box ☐
or alternatively you can download the form from our website **www.lhdpsmilecare.co.uk**

Thank you for your valued referral