PERIODONTAL REFERRAL FORM

1010 W. Exchange Pkwy
Bldg A Suite 1160
Allen, TX 75013

P: 469-663-0393
E: gumspecialtycenter@gmail.com
W: gumspecialtycenter.com

GUM SPECIALTY CENTER

Patient Name

Phone #

Referring Doctor

Phone #

Reason for Referral

- ☐ Periodontal Evaluation Only
- ☐ Implant
- ☐ Crown Lengthening
- ☐ Tissue Grafts
- ☐ Emergency Evaluation (problem focused)
- ☐ Bone Graft
- ☐ Osseous Surgery
- ☐ Gingivectomy
- ☐ Frenectomy
- ☐ Other

Date

Tooth #(s)

Quads

Has the patient had previous periodontal therapy?

- ☐ None
- ☐ Laser Therapy
- ☐ Prophylaxis Only
- ☐ Scaling and Root Planing
- ☐ Surgery

Have you advised the patient of the possibility of extraction of any teeth? ☐ Yes ☐ No
If yes, which teeth?

Has the patient been medically cleared for treatment? ☐ Yes ☐ No

Does the patient require premedication? ☐ Yes ☐ No

Antibiotic Used

Radiographs

- ☐ Please take/send copy
- ☐ Patient will bring copy
- ☐ I will send/please return

Comments

Please

- ☐ Call me before seeing the patient
- ☐ Call me after seeing the patient
- ☐ Alternate recare appointments
- ☐ Do all recare