REFERRAL FORM

SPECIALIST PERIODONTAL REFERRAL FORM

SANDOWN DENTAL & IMPLANT CLINIC ACCEPTS REFERRALS FROM OTHER DENTISTS AND DENTAL PRACTICES. TO MAKE A REFERRAL PRINT THIS PDF AND SEND IT BACK TO US.

Please be assured we will neither approach nor accept your patient for non-referred treatment.

Practice details	
Practitioner name	
Practice address	
Phone	
Email	

Patient details	
Name	
Address	
Date of birth	
Telephone	
Mobile	
Email	
Is this referral urgent	

Reasons for referral

Periodontitis ☐ Periodontitis unresponive to treatment ☐ Connective tissue graft ☐

Periodontal surgery ☐ Fraenectony / soft tissue condition ☐ Surgical crown lengthening ☐

Other: ☐

Medical History
Smoker: Yes ☐ No ☐ Allergies: Yes ☐ No ☐
Medications:
Other relevant Medical History:

Clinical Details and Previous Periodontal Treatment
Please attach periodontal chart if available.

Diagnostic aids

OPG ☐ PA's ☐ CBCT scan ☐ Other radiographs ☐

Signature _____

Date _____

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DENTAL & IMPLANT CLINIC

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