# Periodontist

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WESTERN DENTAL
SPECIALIST GROUP

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| **Referring Clinician Details:** | **Patient Details:** |
|---|---|
| Clinician Name: | Patient Name: |
| Phone: | Phone: |
| Address: | DOB: / / |
| | Address: |

**Treatment:**

☐ General periodontal assessment and management

☐ Periodontal assessment and management of a specific area

☐ Implant assessment and therapy

☐ Recession / Mucogingival concerns

☐ Frenectomy / Pericision

☐ Other: please specify ______________________________________________

**Additional comments:**

**Specify Tooth:**

| R | 18 | 17 | 16 | 15 | 14 | 13 | 12 | 11 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | L |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 48 | 47 | 46 | 45 | 44 | 43 | 42 | 41 | 31 | 32 | 33 | 34 | 35 | 36 | 37 | 38 | |

**Enclosures:**

OPG / PA / CBCT / Other: _____________________

☐ Emailed

☐ Hard copy

☐ Please arrange x-rays

Signature: ________________ Date: ___/___/_____