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: ___/___/_____