PERIODONTAL REFERRAL FORM
386-304-1181

Patient Name: ______________________________ Date: ____________

Referring Doctor: ________________________ Phone: ______________

Reason for Referral

- ☐ Periodontal Evaluation
- ☐ IV Sedation
- ☐ Oral Sedation
- ☐ LANAP
- ☐ Osseous Surgery
- ☐ Extractions
- ☐ Crown Lengthening
- ☐ Implant(s)
- ☐ Hybrid/All-on-X
- ☐ Bone Graft
- ☐ Tissue Grafting
- ☐ Gingival Contouring
- ☐ Frenectomy
- ☐ Perio-Accelerated Osteogenic Orthodontics
- ☐ Pre-prosthetic (Tori Removal/Alveoloplasty)

Tooth #(s): ______________________ Quads: ______________________

Has the patient had previous periodontal therapy?

☐ None ☐ Prophylaxis Only ☐ Scaling and Root Planning ☐ Surgery

Pre-medication requirement? ☐ Yes ☐ No Antibiotic used: ______________

Radiographs: ☐ Please take/send copy ☐ Patient will bring copy
☐ Emailed (front_office@whitewolfdental.com)

Restorative Treatment Plan/Comments: ______________________________

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Please: ☐ Call me before seeing patient ☐ Call me after seeing patient

Dentist Signature: ______________________________ **Date**: ____________

WHITEWOLFDENTAL.COM

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