



DR. EDMOND GHIABI
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PERIODONTAL REFERRAL FORM

FROM:

Dr. _____

Tel: _____

Date: _____

REFERRING:

Name: _____

DOB: _____

Tel: _____

REASON FOR REFERRAL:

Complete periodontal examination

Specific problem:

Area/Tooth #

Gingival recession _____

Deep pockets _____

Mucogingival lesions _____

Bone loss _____

Pathologic lesion(s) _____

Gingival tattoo removal _____

Frenectomy _____

Crown lengthening _____

Periodontal abscess _____

Dental implant(s) _____

Other _____

RELEVANT HISTORY:

Please call the patient

Patient will call to book an appointment

Radiographs are enclosed

Please return radiographs

Please report: in writing

by phone