FOUNDATIONS
PERIODONTICS

FATIMA TIWANA, BDS, MDS
Diplomate American Board of Periodontology

Periodontal Referral Form

Referred by Dr.: _____ Phone: _____

Patient Name: _____ Phone: _____

Contact Me: ☐ Prior to seeing the patient ☐ After initial consultation ☐ Letter corresponence

Reason for Referral: ☐ Complete Periodontal Evaluation ☐ Limited Evaluation

For limited evaluations, if an area is not indicated, a complete periodontal evaluation will be completed.

Specify Area for Limited Evaluation

Area: ☐ UR ☐ UL ☐ LR ☐ LL **OR** Tooth # _____ Tooth # _____ Tooth # _____

***If more than 3 teeth, a complete periodontal evaluation will be completed.**

- ☐ Gingival Augmentation
- ☐ Cosmetic Gingival Contouring
- ☐ Frenectomy
- ☐ Oral Pathology/Biopsy
- ☐ Scaling/Root Planning
- ☐ Crown Lengthening Surgery
- ☐ Guided Tissue Regeneration
- ☐ Pocket Reduction Surgery
- ☐ Extraction
- ☐ Ridge Augmentation
- ☐ Tooth Uncover/Exposure
- ☐ Emergency/Abscess
- ☐ Dental Implant: ☐ Tooth ☐ Full Maxillary ☐ Full Mandibular
- ☐ Peri-Implantitis
- ☐ PAOO (Periodontally Accelerated Osteogenic Orthodontics)
- ☐ Other _____

Periodontal Treatment History

☐ Prior to seeing the patient
☐ Quad SRP Quads: ☐ UR ☐ UL ☐ LR ☐ LL Date Completed: _____

Radiographs *(please email if available)*

☐ FMX Available ☐ BWX or PA's Available Date: _____
☐ Please take new radiographs

Future Restorative Needs

☐ Crown(s) ☐ Removeable prosthetics ☐ Fixed prosthetics ☐ Other: _____

Additional Comments: _____

_____

Maintenance

☐ We prefer to do maintenance after active therapy ☐ We prefer to alternate
☐ We prefer your office to do periodontal maintenance and will continue to do caries exams

Referring Dentist's Signature: _____

126 Pioneer Trail • Chaska, MN 55318 • 952.260.2633 • referral@foundationsperio.com
www.FoundationsPSA.com/Perio