calgaryperio™

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Periodontal Health & Dental Implants

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Referred by Dr._____

Referring Office (Name/Phone/Fax): _____

REQUIRED INFORMATION:

Introducing: _____ (H): _____
First (Given name) / Last (Surname)

(Month/Day/Year)
D.O.B.: _____/_____/_____ Male/Female_____ (W): _____

Referral Date: _____ Email: _____

Please **fax or email** the referral and **forward** all radiographs via email/mail. **PLEASE DO NOT send x-rays with the patient.** **Is this patient covered under a government plan such as AISH? Yes or No**

Referred For:

- ☐ Comprehensive Periodontal Examination
- ☐ Dental Implant Consultation — Site: _____
  Please provide Preferred Implant (Nobel/Straumann/3i/Other)
- ☐ Periodontal Plastic Surgery (Gingival Grafting) — Site: _____
- ☐ Single Site Assessment (no other areas of concern) — Site: _____
- ☐ Crown Lengthening — Site: _____
- ☐ Other:_____

Radiographs / Periodontal Records (please forward all available at time of Referral)

- ☐ **E-mailed/Mailed (Panorex/BW's/PA's/FMX/Ceph/Probing Chart)** _____

Comments (if any)

☐ **Urgent Priority Required**