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American Board of Periodontolog
Periodontics and Dental Implant

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REFERRAL FORM

Date:_____

Referred patient name:_____

DOB:_____ Contact number:_____

Referred by:_____

Referral office location (if applicable)_____

1. **Reason for referral**
   - ___ Complete Periodontal Evaluation
   - ___ Periodontal surgery
   - ___ Crown Lengthening
   - ___ Mucogingival Problem (Soft tissue grafting)
   - ___ Extraction
   - ___ Ridge Augmentation/Bone Graft
   - ___ Implants
   - ___ Sinus Lift
   - ___ Surgical Exposure of impacted tooth/teeth
   - ___ Sedation
   - ___ Other
2. **Area of Chief Concern:**
   Tooth/Teeth#_____
3. **Radiographs**
   - ___ Radiographs will be provided for this patient
   - ___ Please take appropriate radiographs
4. **Tentative Restorative Plans:**
5. **Remarks:**

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