Glen PERIODONTICS & 2.0 IMPLANT DENTISTRY

☐ **Dr. Joshua Hassan**

☐ **Dr. Jennifer Adhami**

847.729.0200

Referral Fax - No Cover Sheet Required

From: Dr. _____ Date _____

Patient Name: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Requires Premedication: ☐ Yes ☐ No Drug Allergies: _____

Reason for Referral:

___ Comprehensive Periodontal Evaluation _____
___ Localized Periodontal Evaluation # _____
___ Gingival Recession/Root Coverage # _____
___ Call Doctor before/after examining patient

___ Contact patient after _____ days
___ Implant Consultation # _____
___ Crown Lengthening # _____
___ Emergency _____
___ Other _____

Radiographs: (please circle the appropriate)

___ Take FMX/send copy to me
___ I am mailing FMX/pano/individual periapicals

___ Patient bringing FMX/pano/individial periapicals
___ Please duplicate & return my X-rays
___ FMX / PAN - taken on _____

Comments: _____

_____

_____

_____

Restorative Treatment Plans include: _____

_____

_____

_____

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