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## 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/individual periapicals
- \_\_\_ Please duplicate & return my X-rays
- \_\_\_ FMX / PAN - taken on \_\_\_\_\_

### Comments:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### Restorative Treatment Plans include:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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