DR. IAN M. TURNER
PERIODONTICS AND IMPLANT SURGERY

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Date:_____
Referring Doctor:_____ Phone:_____
Patient:_____
Phone: Home_____ Cell _____

I AM REFERRING THIS PATIENT FOR:

( ) Implant Consultation
( ) Complete Periodontal Evaluation and Treatment
( ) Limited Periodontal Evaluation and Treatment ( ) UR. ( ) UL, ( ) LR, ( ) LL
( ) Emergency/Abscess
( ) Crown Lengthening
( ) Recession/Grafting
( ) Periodontal Plastic Surgery
( ) Frenum Problem
( ) Expose Unerupted Teeth
( ) Other: _____

PERIODONTAL TREATMENT DONE BY REFERRING OFFICE

( ) Scaling and Root Planing: ( ) UR, ( ) UL, ( ) LR, ( ) LL
Date Done: _____
( ) Frequent Periodontal Maintenance
( ) Other _____

RADIOGRAPHS: FMX ____ BWX ___ PA's ____ PANOREX ____

( ) Are being forwarded to you ( ) Are accompanying patient
( ) Are available at our office ( ) If needed, please take films and send me a set.

TREATMENT DISCUSSION

Please call me : ( ) Before ( ) After your examination.

PERTINENT MEDICAL HISTORY:

( ) Premedication _____
( ) Drug Allergy _____
( ) Other

COMMENTS:_____

Please keep the bottom copy for your records as documentation of this referral