oralhealth specialists®

Patient Referral Checklist

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Diplomate American Board of Periodontology & Dental Implant Surgery

Patient Name: _____ **Referring Doctor:** _____

Chief Concern: **Date:** _____

What is the primary reason the patient is being referred to our office?

_____

_____

Has treatment been previously performed in this area? ☐ YES ☐ NO

If yes, please provide a complete list of dates, type of treatment, materials used, doctors involved, etc.

_____

_____

What is the history of their current condition? (Progressing recession, fractured tooth, caries risk etc.)

_____

Does the patient have pain? ☐ YES ☐ NO Does the patient have swelling? ☐ YES ☐ NO

Interim treatment as provided by referring doctor

Medications prescribed _____

Provisional restoration _____

Essix/ t-RPD _____

Endodontic therapy _____

Are there any medical concerns? ☐ YES ☐ NO Has a physician been consulted? ☐ YES ☐ NO

_____

Documentation available:

☐ Photographs ☐ Diagnostic casts ☐ Periodontal charting ☐ Radiographs -type _____

Proposed treatment plan:

What is your proposed treatment plan?

_____

_____

Coordination with interdisciplinary team doctors:

Have any other doctors been consulted regarding this treatment plan? ☐ YES ☐ NO

Please list:

_____

_____

Additional comments:

_____

_____

_____

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