



THE ROBERTS-HARRY
DENTAL CLINIC

PERIODONTIC REFERRAL FORM

PRACTICE DETAILS

| | |
|--------------------|---------------|
| Referring Practice | Date Referred |
| Referring Dentist | Tel. No. |
| Address | Post Code |
| Email | |

PATIENT DETAILS

| | | | |
|-------------------|--------------------------|------------------------------|-----------------------------|
| Patients Name | Email | | |
| Patients Address | Post Code | | |
| Telephone Numbers | Home | Work | Mobile |
| Date of Birth | Is this referral urgent? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

REASON FOR REFERRAL (please tick all relevant boxes)

| | |
|--|--|
| <input type="checkbox"/> Opinion only | <input type="checkbox"/> Crown lengthening |
| <input type="checkbox"/> High BPE score | <input type="checkbox"/> Possible medical factors/diabetes |
| <input type="checkbox"/> Perio disease advanced for age | <input type="checkbox"/> Suspected perio-endo lesion |
| <input type="checkbox"/> Rapid periodontal breakdown >2mm attachment lost in one year | <input type="checkbox"/> Other (please specify below) |
| <input type="checkbox"/> C/T/free gingival grafts | _____ |
| <input type="checkbox"/> Tooth hemisection/root re-section | _____ |
| <input type="checkbox"/> Periodontal surgery with or without regenerative techniques | _____ |

BRIEF HISTORY

thank you for your valued referral

ELIZABETH ROBERTS-HARRY BDS, MDENTSCI(RESTORATIVE)
SPECIALIST IN PERIODONTICS

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