

PERIODONTAL REFERRAL FORM

Referred By Dr: _____

Address: _____

Telephone: _____ **Email:** _____

Patient details: Mr/Mst/Mrs/Ms

Surname: _____ **Forename:** _____

Date of Birth: _____ **Age:** _____ Male Female

Address: _____

Telephone: Home _____ **Mobile:** _____ **Office:** _____

Reason for Referral:

- Periodontal Evaluation
- Graft for Root Coverage
- Crown lengthening
- Prior to restorative
- Periodontal Regeneration Therapy
- Guided Bone Regeneration
- Dental Implants
- Other

PREVIOUS PERIODONTAL THERAPY:

- None
- Scaling, Root Planing
- Maintenance Only

Radiographs:

- full mouth periapical radiographic
- bite wing radiographs
- panoramic radiographs
- other _____

Comments:

SIGNED

DATE

**Dr. kuljeet Mehta, BDS, FDS RCS (Eng), MClintDent, MRD (Perio) RCS (Ed) Registered Specialists in Periodontics.
Practice Limited to Periodontics and Dental Implants.**

Procedures include: Treatment of Periodontal Disease - Gum Disease, Dental Implants, Cosmetic Periodontics including Gum Grafting, Crown Lengthening, Ridge Preservation, Bone Regeneration & Bone Grafting.

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