CAUSEWAY &
BLACKHORSE WAY
DENTAL PRACTICE

Periodontal Referral Form

PATIENT INFORMATIN:

Title:

Forename:

Surname:

DOB:

Address:

Telephone:

Mobile:

Email:

Medical history:

Medications:

Allergies:

Smoker: YES / NO / PAST
No Per Day : _____

☐ **Periodontal Assessment and Treatment** ☐ **Crown Lengthening**

Reason for referral/reason for treatment:

_____

_____

_____

Recent x-ray(s) & photos included: YES / NO

OH: GOOD / MODERATE / POOR

Regular Attender to GDP: YES / NO

Regular Hygiene Attender: YES / NO

Please ensure the patient is aware of the approximate costs of private periodontal care (See price list).

Referring dentist:
Address:

Date of Referral:
Telephone:

Office use only:

Actions Needed: _____

_____

Dentist Referral Allocated to: _____

Signature: _____ Date: _____

Once you have completed this form, please submit it by post to our practice manager.
All information provided will be treated with the strictest confidence. Thank you.

The Causeway Dental Practice, 8 Causeway, Horsham, West Sussex, RH12 1HE