DEER RIDGE
PERIODONTICS & IMPLANT DENTISTRY

DR. ANGELA WACIUK
Periodontist

Patient Referral Form

Referral Date (YYYY-MM-DD) _____ Time _____

Patient Information

_____ Last Name _____ First Name _____ DOB (YYYY-MM-DD) _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email _____

Referring Doctor

Name _____ Phone _____ Email _____

Reason for Referral

Consultation

- ☐ Gum Grafting
- ☐ Crown Lengthening
- ☐ Dental Implants
- ☐ Pocket Reduction Surgery
- ☐ Treatment of Periodontal Disease
- ☐ Laser Periodontal Surgery/LANAP
- ☐ Sedation-oral, N2O and IV
- ☐ Bone Grafting
- ☐ Other

Reason for CBCT

- ☐ Dental Implants
- ☐ Disease/syndrome/tumor/condition
- ☐ Impacted/delayed/malpositioned/extra teeth
- ☐ Other reason (not on list)
- ☐ Troublesome/painful/cracked tooth/extra canal (Endodontic)
- ☐ Wisdom teeth
- ☐ Temporomandibular joints (TMJ)

Remarks or special instructions

_____

_____

☐ 18	☐ 17	☐ 16	☐ 15	☐ 14	☐ 13	☐ 12	☐ 11		☐ 21	☐ 22	☐ 23	☐ 24	☐ 25	☐ 26	☐ 27	☐ 28	
☐ 48	☐ 47	☐ 46	☐ 45	☐ 44	☐ 43	☐ 42	☐ 41		☐ 31	☐ 32	☐ 33	☐ 34	☐ 35	☐ 36	☐ 37	☐ 38	☐ 99

Radiographs / Lab Reports / Attachments

- ◯ Attached with this form
- ◯ Being mailed
- ◯ Given to patient
- ◯ Please take

Date radiographs were taken (YYYY-MM-DD) _____

Delivery Method (for CBCT only)

- ◯ CBCT DICOM file
- ◯ Email
- ◯ Disc ($15/disc charged to the dentist)
- ◯ CBCT Report
- ◯ Email