Referral Slip

Date: ____/____/____ Referred By: ______________________________

Introducing:____

Sex: M / F DOB:____/____/____

Patient Phone#: ( ) _______________ Alternative#: ( ) _______________

Consultation for:

☐ Evaluation and treatment of periodontal disease
☐ Limited examination: area _____________

☐ Crown lengthening
☐ Frenum
☐ Recession / mucogingival issue
☐ Bone loss (bone graft needed)
☐ Biopsy
☐ Hard / soft tissue augmentation

_________ Implant(s) area _____________
_________ Extraction and socket preservation: area _____________
_________ Other: ____

Radio graphs:

☐ Please take any needed x-rays
☐ we are sending x-ray(s)
☐ given to patient to bring to appointment

Comments/notes:

☐ Please call before the consultation

____
____
____

If you are taking any medication, please prepare a list including dosages and bring it with you to your consultation appointment.

Your confidence is greatly appreciated.

WWW.PERIO-INDY.COM

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Indianapolis, IN 46250

O: 317-436-7162
F: 317-436-7163

DIRECTIONS:

At this time, Google maps and most GPS do not accurately show directions to our office. Please enter the Sycamore Springs office complex from 82nd Street.

We are located in the southwest corner of the complex.