Palermo-Edwards & Cacchillo
Periodontics & Dental Implants

PATIENT REFERRAL SLIP

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614-861-8077
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Patient Information

Name_____ Date _____

Referring Doctor_____

Radiographs ___ BW ___ PANO ___ Full Mouth ___ CT Scan

___Radiographs emailed to ___ Mailed ___ Given to patient ___ None Avail.
pec@periohealth.org

Reasons for Referral

___Periodontal Exam (area/s of concern)_____

Severity: ___ mild ___ moderate ___ severe

___Implant(s) #_____

___Soft Tissue Graft #_____

___Crown Lengthening #_____

___Ridge Augmentation #_____

___Exposure #_____

___Oral Pathology (area of concern)_____

___Other_____

Comments_____

_____

_____

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