

PERIODONTAL - DENTAL IMPLANT REFERRAL FORM



PERIODONTICS
&
DENTAL IMPLANT CENTRE

- Dr. Andres Orozco**
BDS(Col) MSc(Chile) MDSc(Qld) FRACDS(Perio)
- Dr. Chris Bates**
BDS(Adel) MClInDent(Lond)
DClinDent(Adel) FRACDS(Perio)
- Dr. Saeideh Nobakht**
DDS (Hons), DClinDent (Otago),
MRACDS (Perio)
- First Available Periodontist**

Indooroopilly Medical Centre
Unit 7, 66 Station Rd,
Indooroopilly Qld 4068
Phone: 07 3878 1555
Fax: 07 3878 1500
Email: perioidimplants@bigpond.com
www.periodonticsandimplants.com.au

Patient's Name _____ D.O.B. / / _____

Patient's Address _____

Telephone _____

- Appointment already arranged
- Patient will call for appointment
- Please call patient for an appointment

PATIENT REFERRED FOR:

- IMPLANT EVALUATION
 - Do not arrange Implant Prosthodontics
 - Please arrange Implant Prosthodontics
- PERIODONTAL EVALUATION. All restorative requirements will be referred back to the referring dentist.
- CROWN LENGTHENING
- GRAFTING
- CANINE EXPOSURE
- OTHER, Please Specify

Areas of concern include: _____

8	7	6	5	4	3	2	1		1	2	3	4	5	6	7	8
8	7	6	5	4	3	2	1		1	2	3	4	5	6	7	8

Medical History Comments _____ Smoker YES NO

Referring Dentist _____ Telephone _____

Date of Referral / / _____

Further comments _____

Please select preferred location:

- Indooroopilly
- Toowoomba