

# PERIODONTAL - DENTAL IMPLANT REFERRAL FORM



**PERIODONTICS**  
&  
**DENTAL IMPLANT CENTRE**

- Dr. Andres Orozco**  
BDS(Col) MSc(Chile) MDS(Chile) FRACDS(Perio)
- Dr. Chris Bates**  
BDS(Adel) MClintDent(Lond)  
DClinDent(Adel) FRACDS(Perio)
- First Available Periodontist**

Indooroopilly Medical Centre  
Unit 7, 66 Station Rd,  
Indooroopilly Qld 4068  
Phone: 07 3878 1555  
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Email: [perioimplants@bigpond.com](mailto:perioimplants@bigpond.com)  
[www.periodonticsandimplants.com.au](http://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