CAPITAL REGION
Periodontics & Dental Implants

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Referral For Periodontal/Implant Consultation

Date of Referral: _____

Patient: _____ **Telephone:** _____

Referred by: _____ **Telephone:** _____

Please evaluate/consult for:

____ Generalized Periodontal Disease

____ Localized periodontal/restorative needs: _____

____ Specific Area(s): _____

____ Implants: #_____

____ Other: _____

Restorative Treatment:

____ is complete ____ is established ____ is pending outcome of periodontal findings

Tentative Treatment Plan: _____

Radiographs: (FMS taken within last two years is needed for diagnosis of periodontal patients)

____ Emailed (frontdesk@albanyperioandimplants.com) ____ Not available

Additional Comments: _____

_____

Please: ____ call prior to evaluation ____ call following evaluation

____ referral letter following evaluation is sufficient

Please refer to: ____ Capital Region Periodontics

____ Dr. Reed Ference

____ Dr. Sean Ference

____ Dr. Beniel Tamraz

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