

**MOUTH MATTERS REFERRAL PRACTICE:
PERIODONTAL, IMPLANT AND PROSTHODONTIC REFERRAL**

MARK D. HOWDLE BDS, DGD (UK), MDENTSCI(REST DENT.), MFDS RCS (EDIN), GDC REGISTERED SPECIALIST
IN PERIODONTICS. PRACTICE DEVOTED TO PERIODONTICS, IMPLANT AND RECONSTRUCTIVE DENTISTRY



REFERRING DENTIST

NAME	_____	DATE	_____
ADDRESS	_____	TEL	_____
	_____	FAX	_____
	_____ POST CODE _____	EMAIL	_____

PATIENT DETAILS

NAME	_____	HOME	_____
ADDRESS	_____	WORK	_____
	_____	MOB	_____
	_____ POST CODE _____	DOB	_____

RELEVANT MEDICAL HISTORY

PLEASE INCLUDE ANY RADIOGRAPHS AND MODELS WHICH MAY HELP IN EVALUATING THE PATIENT. WE WILL RETURN THEM TO YOU AFTER USE.

TYPE OF REFERRAL (PLEASE TICK)

PATIENT NEW TO YOUR PRACTICE REGULAR ATTENDER

FULL PERIO CASE ASSESSMENT

THE PATIENT IS EXPERIENCING: (PLEASE SPECIFY PARTICULAR PROBLEM AREAS)

PAIN _____

SWELLING _____

BLEEDING _____

BAD TASTE _____

RECURRENT ABSCESSES _____

TOOTH MOBILITY _____

DIFFICULT CHEWING _____

ISOLATED PERIO PROCEDURE

(PLEASE SPECIFY; CROWN LENGTHENING, GUIDED TISSUE/BONE REGENERATION, MUCOGINGIVAL RECESSION, IMPLANTOLOGY);

IMPLANTS

IMPLANT PLACEMENT ONLY

IMPLANT PLACEMENT AND RESTORATION

PLEASE SPECIFY DETAILS OF THE PROBLEM: _____

PROSTHODONTICS

PLEASE SPECIFY: _____

SEDATION REQUIRED (ORAL / IV) Yes No

