Mouth Matters Referral Practice:
Periodontal Referral

Dr Dimitrios Mitsas, DMD, MClinDent
Practice Devoted to Periodontology

Referring Dentist

Name _____ Date _____

Address _____ Tel _____

_____ Fax _____

_____ Post code _____ email _____

Patient Details

Name _____ Home _____

Address _____ Work _____

_____ Mob _____

_____ DOB _____

_____ Post code _____ Email _____

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);

_____

_____

Sedation required (Oral / IV) ☐ Yes ☐ No

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contact@mouthmatters.co.uk • www.mouthmatters.co.uk
Further referral forms can be downloaded from our website