ProSoft
Implantology & Periodontics, PLLC
Christopher M Carney, D.D.S. , M.S.

REFERRAL FORM

Date: _____ Patient Name: _____

Referred By: _____ Patient Phone: _____

Reason for Referral

- ☐ Dental Implants—(Singles or 'All-on-4')
- ☐ Gingival Recession/Root Coverage
- ☐ Extractions/Pre-Prosthetic Surgery
- ☐ Biopsy (site)_____
- ☐ Other _____
- ☐ Periodontal Surgery/Therapy (LANAP)
- ☐ Ridge Augmentation
- ☐ Guided Tissue Regeneration
- ☐ Crown Lengthening
- ☐ Cone Beam CT

Please Specify Teeth or Quadrant

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

Implants/Surgically Guided

- ☐ Nobel Active/Replace
- ☐ Straumann

Radiographs

- ☐ Please take
- ☐ Patient will bring
- ☐ Mailed or Emailed

Periodontal Treatment Completed in Your Office?

- ☐ Prophylaxis/Gross Scaling
- ☐ Scaling/Root Planing
- ☐ Plaque Control
- ☐ Periodontal Maintenance

Additional Comments? Restorative Work? Patient advised of possibility of extractions?

PERIODONTICS, IMPLANTS, DENTAL SURGERY

1759 BROAD PARK CIRCLE S, SUITE 109 • MANSFIELD, TX 76063

PH: 817-225-6600 • FAX: 817-225-6601

EMAIL: INFO@PROSOFTPERIO.COM *WWW.PROSOFTPERIO.COM*