Thibault
PERIODONTICS

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Please email referral with radiographs (last name, first name, date taken), photos, pocket charting, dental history, details of problem or anticipated restorative plan to referrals@thibaultperio.ca.

Referral date: _____ Referral provider: _____

Phone #: _____ Email: _____

Patient: _____ Parents/guardians: _____

Address: _____

City: _____ Postal Code: _____

Phone # (H): _____ (C): _____ Other: _____

***Patient's e-mail address **(REQUIRED)** _____

Date of Birth: ___ / ___ / ___ Gender: _____
Month Day Year

Please see this patient regarding:

- ☐ Comprehensive Perio Exam **(PROVIDE CHARTING AND RADIOGRAPHS)**
- ☐ Specific Perio Exam Location: _____ **(PROVIDE RADIOGRAPHS)**
- ☐ Implant Consultation Location: _____ **(PROVIDE RADIOGRAPHS)**
- ☐ Gingival Graft Location: _____ **(PROVIDE PHOTOS AND RADIOGRAPHS/PAN if available)**
- ☐ Crown Lengthening Location: _____ **(PROVIDE PERIAPICAL)**
- ☐ Exposure Location: _____ **(PROVIDE PANOREX)**
- ☐ Apicoectomy Location: _____ **(PROVIDE PERIAPICAL)**
- ☐ TMD/facial pain **(PROVIDE A PANOREX IF AVAILABLE)**
- ☐ Pathology/Biopsy **(PROVIDE PHOTOS)**
- ☐ Other _____

Detailed description of patient's condition/concerns:

Allergies: _____ **Premed:** _____

Medical Considerations: _____

Patient status: _____

Enclosed:

- ☐ Radiographs **(Please rename all radiographs with your patient's name and date taken)**
- ☐ No recent radiographs ☐ Pocket charting ☐ Photos