PERIODONTAL - DENTAL IMPLANT REFERRAL FORM

PERIODONTICS & DENTAL IMPLANT CENTRE

○ Dr. Andres Orozco
BDS(Col) MSc(Chile) MDSc(Qld) FRACDS(Perio)

○ Dr. Chris Bates
BDS(Adel) MClinDent(Lond)
DClinDent(Adel) FRACDS(Perio)

○ Dr. Saeideh Nobakht
DDS (Hons), DClinDent (Otago),
MRACDS (Perio)

○ First Available Periodontist

Indooroopilly Medical Centre
Unit 7, 66 Station Rd,
Indooroopilly Qld 4068
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Fax: 07 3878 1500
Email: perioimplants@bigpond.com
www.periodonticsandimplants.com.au

Patient's Name D.O.B. / /

Patient's Address

Telephone

○ Appointment already arranged ○ Patient will call for appointment

○ Please call patient for an appointment

PATIENT REFERRED FOR:

○ IMPLANT EVALUATION

○ Do not arrange Implant Prosthodontics
○ Please arrange Implant Prosthodontics

○ PERIODONTAL EVALUATION. All restorative requirements will be referred back to the referring dentist.

○ CROWN LENGTHENING ○ GRAFTING

○ CANINE EXPOSURE ○ OTHER, Please Specify

Areas of concern include:

8	7	6	5	4	3	2	1		1	2	3	4	5	6	7	8
8	7	6	5	4	3	2	1		1	2	3	4	5	6	7	8

Medical History Comments Smoker YES NO

Referring Dentist Telephone

Date of Referral / /

Further comments