SYDNEY SPECIALIST PERIODONTICS

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I am referring: _____ D.O.B:_____

Address: _____

_____ Telephone: _____

This consultation is requested for indicated teeth:

18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28
48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38

- Gingivitis
- Periodontics
- Dental Implants
- Gingival recession / root coverage
- Other soft tissue
- Bone grafting / ridge augmentation / sinus lift
- Crown Lengthening
- Surgical exposure of tooth

Other reason for referral or comments:

_____

_____

_____

Records provided:

- Intra-Oral Radiographs
- Panoramic radiographs
- CT scans
- No records
- Mailed / Emailed
- Coming with patient

Other: _____

Signature: _____ Date: _____

Please print or stamp name: _____ Phone: _____