Dr. Edmond Ghiabi, *Periodontist*
Dr. Negin Ghiabi, *Pediatric Dentist*

PINNACLE
DENTAL SPECIALISTS

PERIODONTAL REFERRAL FORM

FROM:

Dr. _____

Tel: _____

Date: _____

REFERRING:

Name: _____

DOB: _____

Tel: _____

REASON FOR REFERRAL:

☐Complete periodontal examination

☐Specific problem: Area/Tooth #

- ☐Gingival recession _____
- ☐Deep pockets _____
- ☐ Mucogingival lesions _____
- ☐ Bone loss _____
- ☐Pathologic lesion(s) _____
- ☐ Gingival tattoo _____
- ☐ Frenectomy _____
- ☐Crown lengthening _____
- ☐Periodontal abscess _____
- ☐Dental implant(s) _____
- ☐ Other _____

_____

RELEVANT HISTORY:

_____

_____

_____

☐Please call the patient

☐Patient will call to book an appointment

☐Radiographs are enclosed

☐Please return radiographs

☐Please report: ☐in writing ❑by phone

255 Lacewood Dr., Suite 307, Halifax, NS B3M 4G2 • **Tel:** 902.407.7377 • **Fax:** 902.407.4338 • **www.pdsns.ca**