



shaftesbury referrals
excellence in dental care

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periodontic referral form

practice details

Referring Practice _____ Date Received _____
Referring Dentist _____ Tel. No. _____
Address _____
_____ Post Code _____

patients details

Patients Name _____ Email _____
Patients Address _____

Telephone Numbers: Home _____ Work _____ Mobile _____
Date of Birth _____ Is this referral urgent? Yes No

reason for referral (please tick all relevant boxes)

- | | |
|--|--|
| <input type="checkbox"/> Opinion only | <input type="checkbox"/> Crown lengthening |
| <input type="checkbox"/> High BPE score | <input type="checkbox"/> Possible medical factors/diabetes |
| <input type="checkbox"/> Perio disease advanced for age | <input type="checkbox"/> Suspected perio-endo lesion |
| <input type="checkbox"/> Rapid periodontal breakdown
>2mm attachment lost in one year | <input type="checkbox"/> Other (please specify below) |
| <input type="checkbox"/> C/T/free gingival grafts | _____ |
| <input type="checkbox"/> Tooth hemisection/root re-section | _____ |
| <input type="checkbox"/> Periodontal surgery with or without regenerative techniques | _____ |

brief history

investigations (please tick all relevant boxes)

- OPG PA's Other Radiographs Are these enclosed?
Has the patient been informed of the cost of the consultation/treatment? Yes No
Would you like us to provide the maintenance phase of treatment? Yes No

thank you for your valued referral