THORNLEIGH PERIO

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Phone: (02) 8004 3157 | referrals@thornleighperio.com.au

Referral Form

REFERRING CLINICIAN

Referring dentist name

Referral date

Practice name

Phone

Email

PATIENT DETAILS

Patient full name

Date of birth

Patient phone

Patient email

REASON FOR REFERRAL

- [ ] Consultation or 2nd opinion
- [ ] Management of periodontal disease
- [ ] Implant placement
- [ ] Management of mucogingival problem
- [ ] Crown lengthening
- [ ] Other (please specify)
- [ ] Soft or hard tissue augmentation
- [ ] Sinus augmentation
- [ ] Exposure of unerupted tooth
- [ ] Management of peri implant disease

RELEVANT HISTORY AND CLINICAL NOTES

Include periodontal history, key findings, medical information, and urgency if relevant

Please attach relevant radiographs, photographs or documents when emailing.

Email completed referrals to: referrals@thornleighperio.com.au