REFERRAL COMMUNICATION FORM

Date__________________________

Patient Name ____________________________________________________________________

Patient Phone ____________________________________________________________________

Referring Doctor __________________________________________________________________

Appointment on ____________________________ Time_________________

The Area of Major Concern:

☐ Periodontics Related: (Periodontitis, Esthetic, Crown Lengthening, Soft Tissue Augmentation, Smile Line Evaluation and other Pre-Restorative Treatment)

☐ Dental Implant: (Sites, Type of Implant Request, Peri-Implantitis)

☐ Surgical Template: (Provided by Periodontist; Restorative Dentist)

☐ Extraction: (Tooth #, Ridge Augmentation)

☐ Other Information: (Restorative/Prosthetic Treatment Plans, Types and dates of Periodontal Treatment rendered in your office, etc.)

Please forward current X-ray ______________________________________________________

This Patient is: ☐ New to my Practice ☐ # of years in Recall ____________________________

I would like Dr. to call _______________________________ ☐ before or ☐ after examination

I would like Dr. to write _____________________________ ☐ report after exam ☐ report after treatment

RANCHO MIRAGE MEDICAL CENTER
72-780 Country Club Dr., Bldg. D, Ste. 402 | Rancho Mirage, CA 92270
Tel 760.836.1809 | Fax 760.270.9419
Ellie@DrEllieLove.com