



Please send this form along with radiographs at dentperi@dal.ca.
We will contact your patient to arrange an appointment.

REFERRAL TO THE GRADUATE PERIODONTICS CLINIC

REFERRING DENTIST INFORMATION:

Dentist Name: _____ General Dentist Specialist: _____
Practice Name: _____
Address: _____ City/Postal Code: _____
Phone: _____
Email: _____

PATIENT INFORMATION:

Patient Name: _____ Date of Birth (MM/DD/YYYY): _____
Address: _____
Phone: Home: _____ Cell: _____ Work: _____
Email: _____

Reason for referral:

- | | | |
|--|--|--------------------------|
| <input type="checkbox"/> Periodontal Evaluation | <input type="checkbox"/> Soft Tissue Graft | Area/tooth number: _____ |
| <input type="checkbox"/> Implants (single, multiple or full-arch) | <input type="checkbox"/> Peri-Implantitis | |
| <input type="checkbox"/> Astra <input type="checkbox"/> Nobel Biocare <input type="checkbox"/> Straumann | <input type="checkbox"/> Crown Lengthening | |
| <i>Please indicate to be restored at:</i> | <input type="checkbox"/> Pre-Ortho (Frenectomy, Grafting, Impacted
Tooth Exposure) | |
| <input type="checkbox"/> Your office <input type="checkbox"/> Dalhousie | <input type="checkbox"/> Mucocutaneous disease (<i>select the severity of the disease</i>) | |
| <input type="checkbox"/> Bone Grafting/Sinus Lift | <input type="checkbox"/> Minimal <input type="checkbox"/> Moderate <input type="checkbox"/> Severe | |
| <input type="checkbox"/> Extraction | Tooth number: _____ | |

Comments (indicate your prosthetic/restorative plan if applicable):

Signature of the Referring Dentist: _____ Date: _____

As an educational facility:

- We welcome referrals that align with our graduate residents' specialized training in advanced periodontal care.
- If a patient does **not** require advanced periodontal treatment, we will kindly refer them back to your office for continued care.