

Fully complete forms should be faxed to 780.407.5701 or sent to perio@ualberta.ca; a copy should be saved at the referring office.

Date _____

PATIENT INFO

Patient's name _____ Birthdate (MM/DD/YYYY) _____

Preferred phone _____ PHN _____

Alternate phone _____ Email _____

Address _____

REFERRED BY

Name _____ Email _____

Office phone _____ Fax _____

Address _____ Signature _____

REASON FOR REFERRAL

- | | | |
|---|--|---|
| <input type="checkbox"/> Complete periodontal examination | <input type="checkbox"/> Orthodontic requirements | <input type="checkbox"/> Ridge augmentation |
| <input type="checkbox"/> Crown lengthening | <input type="checkbox"/> Fiberotomy | <input type="checkbox"/> Implant assessment |
| <input type="checkbox"/> Esthetic | <input type="checkbox"/> Crown exposure | <input type="checkbox"/> Other |
| <input type="checkbox"/> Functional | <input type="checkbox"/> Frenectomy | <input type="checkbox"/> Specific exam for: _____ |
| <input type="checkbox"/> Tissue graft on teeth #s | <input type="checkbox"/> Laser gingival recontouring | |

Restorative plan and comments, including areas/teeth numbers

Radiographs

- None With patient Emailed

Patients will be assigned to a periodontology graduate student who, under the supervision of a licensed faculty member, will complete assessments and treatment. The periodontology graduate program will contact the patient for the appointment.

The Canadian Dental Care Plan is accepted.