UNIVERSITY OF ALBERTA

School of Dentistry
11400 - University Ave
Edmonton, Alberta, Canada T6G 1Z1
Tel: 780.407.5528
Email: perio@ualberta.ca

Periodontology Graduate Program Clinic

Date _____
Patient Name _____
Patient Telephone _____
Date of Birth _____
Address _____
Email _____

Referred for:

Complete Periodontal Examination _____
Specific Examination Regarding _____
Crown Lengthening, Esthetic _____ or Functional _____
Tissue Graft, Teeth #'s _____
Orthodontic Requirements: Fiberotomy _____ Crown Exposure _____
Frenectomy _____
Laser Gingival Recontouring _____
Ridge Augmentation _____
Implant Assessment, Areas _____
Radiographs will be provided: Yes or No
Other _____

Restorative Plan and Comments:

_____

_____

_____

Referred By _____

Office Telephone _____

Please fax 780-407-5701 or email perio@ualberta.ca this referral and we will contact the patient to schedule the appointment. All information must be complete on referral form.