EASTMAN
INSTITUTE FOR ORAL HEALTH

UNIVERSITY of ROCHESTER MEDICAL CENTER
Medicine of the Highest Order

PERIODONTICS CLINIC
REFERRAL FORM

625 ELMWOOD AVENUE, ROCHESTER, NY 14620
TEL: (585)275-1147 FAX: 585-276-2941
EMAIL: edc_recordroom@urmc.rochester.edu

Date: _____

Referring Doctor's Information

Name: _____Facility Name: _____

Telephone: _____ Fax: _____

Patient's Information

Patient Name: _____

DOB: _____

Primary phone number: _____

Parent/Guardian Name: _____

Reason for referral:

☐ Consultation for Periodontal Treatment: ☐ Generalized Periodontitis
☐ Localized Periodontitis

☐ Consultation for implant/s: #_____

☐ Consultation for bone augmentation: #_____

☐ Consultation for crown lengthening: #_____

☐ Consultation for gingival recession/s: #_____

☐ Consultation for gingivectomy/s: #_____

☐ Consultation for tooth uncovery: #_____

☐ Consultation for frenectomy: ☐ Maxilla ☐ Mandible

☐ Consultation for accelerated orthodontics: ☐ Maxilla ☐ Mandible ☐ area: _____

☐ Consultation for biopsy: ☐ Soft tissue ☐ Hard tissue ☐ area:_____

☐ Other: _____

Radiographs:

☐ None ☐ Bitewings ☐Panoramic ☐CBCT Date of last xray: _____

Periodontal Treatment completed:

☐ Prophy Date: _____

☐ Scaling and Root Planing Date: _____

☐ Periodontal maintenance Date: _____

☐ None

Comments:

_____

_____

_____

Visit our website for more details:

https://www.urmc.rochester.edu/dentistry/education/periodontology.aspx