PERIODONTAL REFERRAL LETTER

FROM
DATE
PATIENT
PHONE #(S)

GASPER PERIODONTIST

TO: Christina Gasper, DDS, MS
450 Sutter Street, Suite 2336 San Francisco, CA 94108
415 986 4664 T 415 986 1798 F
appointments@christinagasper.com

REFERRED FOR

- ☐ Periodontal evaluation, diagnosis, and therapy:
- ☐ Dental implant evaluation and therapy:
- ☐ Continued on Reverse

OUR MAIN CONCERNS

☐ Significant bleeding on probing:	☐ Crown lengthening needed:
☐ Deep probing depths:	☐ Orthodontics:
☐ Bone loss/deformities:	☐ Smile line/gingival levels:
☐ Deep furcations:	☐ Edentulous ridge augmentation:
☐ Tissue recession/root exposure:	☐ Extract and preserve ridge:
☐ Lack of protective attached gingiva:	☐ Dental implants proposed:
☐ Root sensitivity:	☐ Tooth mobility:
☐	☐ ☐ Continued on Reverse

PERTINENT HISTORY

- Patient of Record: ☐ New ☐ Since (MONTH/YEAR):
- Plaque control motivation/dexterity: ☐ Excellent ☐ Needs Improvement/Reinforcement
- Recommended maintenance interval:_____months. Compliance has been: ☐ Good ☐ Fair ☐ Insufficient
- Date of last maintenance visit (MONTH/YEAR):
- Active periodontal therapy already performed:
- ☐ Quadrant Scaling and Root Planing (MONTH/YEAR): ☐ Our Office ☐ Other:
- ☐ Perio Surgery (MONTH/YEAR): Treated by: Areas:
- ☐ Anti-Microbial Therapy:

RESTORATIVE AND/OR OTHER DENTAL NEEDS

- ☐ Patient is Aware ☐ Patient has not yet had restorative consultation

Crown/Veneers:	☐ Implants:
Fixed Bridges:	☐
Removable Prosthesis:	☐

IMPORTANT PATIENT INFORMATION

- Readiness Level: ☐ High (understands problem(s) and wants treatment) ☐ Unknown ☐ May Be Low
- Patient's Concerns/Stated Needs:
- ☐ Continued on Reverse

CURRENT RADIOGRAPHS (FMX & VERTICAL BWX)

- ☐ Will be forwarded to your office before appointment.
- ☐ Unavailable/Out of date. Please have a new FMX taken and send a copy to our office.
- ☐

☐ Have Dr. Gasper call our office to discuss our patient before the examination appointment. She should speak directly to:_____

Signatures:

DOCTOR:_____ HYGIENIST:_____