FAIRWATER GREEN
DENTAL PRACTICE

Periodontal Referral Form

REFERRER DETAILS:

DENTIST'S NAME: _____

PRACTICE NAME, ADDRESS: _____

_____

DENTIST EMAIL: _____

PATIENT DETAILS:

TITLE & FULL NAME: _____

DoB: ___/___/___ TEL NO:_____ EMAIL:_____

ADDRESS: _____

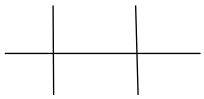
_____

Relevant Medical History: _____

_____

Smoking Status:

Current Smoker ☐ Ex-smoker ☐ Non-smoker ☐

BPE 

Radiographs enclosed? Yes ☐ No ☐

Reason for referral: Periodontitis ☐ Peri-implantitis ☐
Crown Lengthening ☐ Soft tissue grafting/root coverage ☐

Previous Periodontal Treatment:
By Hygienist ☐ By Dentist ☐ By Specialist ☐

CLINICAL DETAILS: _____

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Please send referral to:
Fairwater Green Dental Practice, 6 Fairwater Green, Cardiff CF5 3BA
Or email cardiffperio@gmail.com