FAIRWATER GREEN
DENTAL PRACTICE

Periodontal Referral Form

REFERRER DETAILS:

DENTIST'S NAME: _____

PRACTICE NAME, ADDRESS: _____

_____

EMAIL: _____

PATIENT DETAILS:

TITLE & FULL NAME: _____

DoB: _____

ADDRESS: _____

_____

TEL. NO: _____

EMAIL: _____

Relevant Medical History: _____

_____

Smoking Status:

Current Smoker ☐ Ex-smoker ☐ Non-smoker ☐

BPE _____ Radiographs enclosed? Yes ☐ No ☐

Previous Periodontal Treatment:

By Hygienist ☐ By Dentist ☐ By Specialist ☐

CLINICAL DETAILS: _____

_____

Please include a Periodontal Diagnosis:

_____

_____

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