PIETER J VAN HEERDEN

SPECIALIST IN PERIODONTICS

This form is to be completed by a referring Dentist only.

REFERRAL DETAILS

Periodontal assessment & treatment Yes ☐ No ☐

Gingival recession Tooth:

Crown lengthening Tooth:

Exposure of impacted canine Tooth:

Frenectomy Maxilla ☐ Mandible ☐

Implant assessment & treatment

Surgery only ☐ Surgery & Restorative ☐

8	7	6	5	4	3	2	1		1	2	3	4	5	6	7	8
8	7	6	5	4	3	2	1		1	2	3	4	5	6	7	8

PATIENT DETAILS

Patient Surname Initials Title D/O/B

Address

Phone (H) Phone (W)

MEDICAL CONCERNS

Radiographs enclosed Yes ☐ No ☐

REFERRING DENTIST'S DETAILS

Referring Practitioner Date

Address

Phone Fax

REQUESTS & REMARKS

OFFICE USE ONLY

Appointment date Date contacted

PLEASE POST OR FAX THIS FORM TO US

14 Spencer Street St Albans Herts AL3 5EG
Tel: 01727 831311 Fax: 01727 838866 Email: info@perio-dontics.co.uk