DR.TARA M. HABIJANAC* DR. DONALD R. HABIJANAC

Periodontal Microsurgery
Dental Implants
Regenerative and Reconstructive Surgery

A Periodontal Practice Committed to Excellence

Ph: (403) 278-3177, 1-800-866-3177 **Fax:** (403) 225-2557 **Web:** www.MicroPerio.com
Address: Suite 100 - 10601 Southport Road S.W., Calgary, Alberta, Canada T2W 3M6

Name: ______________________ Address: ______________________

Date of Birth: ______________________ Phone: ______________________

Insurance Info: ____

Medical Alerts: ____

REFERRAL FOR PERIODONTAL EVALUATION

REASON FOR REFERRAL

Comprehensive Exam

- ❏ Pocketing
- ❏ Furcation Involvements
- ❏ Crown Lengthening, multiple quadrants
- ❏ Mucogingival Exam, multiple quadrants
- ❏ Implants, multiple quadrants
- ❏ Pre-prosthodontic
- ❏ Pre-orthodontic

Specific Exam (Same quadrant/or 1-2 teeth)

- ❏ Crown Lengthening
- ❏ Mucogingival Exam
- ❏ Implants
- ❏ Sinus Augumentation
- ❏ Ridge Augumentation
- ❏ Regeneration
- ❏ Extractions
- ❏ Exposure Unerupted Tooth
- ❏ Single tooth, Furcation or pocket

CURRENT RECORDS

Radiographs (within 1 yr)

- ❏ FMX
- ❏ Periapical(s)
- ❏ Bitewings(s)
- ❏ Panoramic
- ❏ Tomography

 # Films:__________
Date taken: ____________________

- ❏ **Being emailed**
- ❏ **Given to patient**
- ❏ **No x-rays**
- ❏ **Please take x-rays**

Other Records

- ❏ Current Periodontal Probings
- ❏ Study Models
- ❏ Diagnostic Wax-Up

IMPLANTS

Preferred System:

- ❏ Straumann
- ❏ Astra
- ❏ Other_______________

Radiographic Guide / Surgical Guide:

- ❏ Provided by dentist
- ❏ Provided by periodontist

COMMENTS: ____
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Patient to call for an appointment - Please be flexible when scheduling your appointment.
This time is being reserved exclusively for you.

Referring Doctor: ______________________ Date: ______________________

Please Fax or Mail
Thank-you for the courtesy of your referral!

REFERRING DR.'s COPY (white) PERIODONTIST's COPY (white)