TRACEY BELL®
DENTAL AND AESTHETIC MEDICAL CLINIC

Head Office
The Tracey Bell Clinic
Kensington Road
Douglas
IM1 3PE

Call Centre: 01624 613323

PERIODONTAL REFERRAL FORM

- Patient Name: _____
- Phone No: _____

- Referring Doctor Name: _____
- Phone No: _____
- Address: _____

- **Reason for Referral**

  - ◯ Periodontal Evaluation Only
  - ◯ Bone Graft
  - ◯ Implant
  - ◯ Osseous Surgery
  - ◯ Crown Lengthening
  - ◯ Gingivectomy
  - ◯ Tissue Grafts
  - ◯ Frenectomy
  - ◯ Emergency Evaluation (problem focused)
  - ◯ Other: _____

  Tooth #(s) _____ Quads: _____

- **Has the patient had previous periodontal therapy?**

  - ◯ None
  - ◯ Prophylaxis Only
  - ◯ Antimicrobial Therapy
  - ◯ Scaling and Root Planning
  - ◯ Surgery

Have you advised the patient of the possibility of extraction of any teeth? ◯ Yes ◯ No

- If **yes** which teeth?

_____

_____

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Tracey Bell
Castletown
12 Malew Street
Castletown
IM9 1AB

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- **Does the patient require premedication?** ◯Yes ◯No

- Antibiotic used: ◯Yes ◯No

If yes: _____

- **Radiographs / Photographs:**

◯ Please take / send copy
◯ Patient will bring copy
◯ I will send ◯ Please return ◯ No return needed

Your Restorative Plans

_____

_____

Comments: _____

_____

Please

◯ Call me before seeing the patient

◯ Call me after seeing the patient

◯ Alternate re-care appointments

◯ Do all re-care

General Dentists name: _____

Signature: _____

Date: _____/_____/_____