LSU Health Sciences Center

SCHOOL OF DENTISTRY

Department of Periodontics – **Referral Form**
1100 Florida Ave., Rm 4312H – 4th Floor
New Orleans, La. 70119
Appointment Phone (504) 941-8390 * Referral Fax (504) 941-8279
periopg@lsuhsc.edu

Patient's Name:_____ Date of Birth:____/____/_____

Address:_____

Parent/Guardian Name: _____

Phone Number: (Home):_____(Work):_____(Mobile):_____

Referring Dentist: Dr._____

Phone Number:_____

Address:_____

Reason for Referral

Complete Periodontal Exam: □ Limited Periodontal Exam: □ Area / Tooth:_____
Presence of Periodontal Pockets: □ _____
Implants: □_____
Gingival Recession: □_____
Crown Lengthening: □_____
Ridge Augmentation: □_____
Extraction: □_____
Gingivectomy: □_____
Uncovering of Unerupted Teeth: □_____
Other:_____

Periodontal Treatment History

No previous periodontal treatment: □ Scaling and root planing: □ _____
Surgery: □_____
Other:_____

Radiographs

Are you sending copies of recent x-rays? Yes: □ No: □ Panoramic X-ray: Yes □ No □
Please e-mail current x-rays to: periopg@lsuhsc.edu
Do we need to take new x-rays? Yes: □ No: □
Is there any restorative dentistry that needs to be completed? Yes: □ No: □
If yes, please explain:_____

Comments:_____

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