ACHARYA
PERIODONTICS & DENTAL IMPLANTS

Referral Form

Date: ________________________ **Referring Doctor:** ____

Patient's Name: ____ **Phone:** _______________________

REASON FOR REFERRAL: (SELECT ALL THAT APPLY)

- ❑ Comprehensive/Full Mouth Periodontal Exam
- ❑ Limited Periodontal Exam, area(s): _____________________________
- ❑ Scaling and Root Planing
- ❑ Crown Lengthening, area(s): _____________________________
- ❑ Dental Implant/Extraction with Socket Preservation, area(s): _____________________________
- ❑ Frenectomy
- ❑ Gingival Recontouring, area(s): _____________________________
- ❑ Periodontal Surgery, area(s): _____________________________
- ❑ Recession, Free Gingival Graft, Soft Tissue Graft/Allograft, area(s): _____________________________
- ❑ Other(s): _____________________________

RADIOGRAPHS

- ❑ Need to be taken
- ❑ Mailed

Date taken: __ /___ /___

- ❑ Patient will bring
- ❑ E-mailed

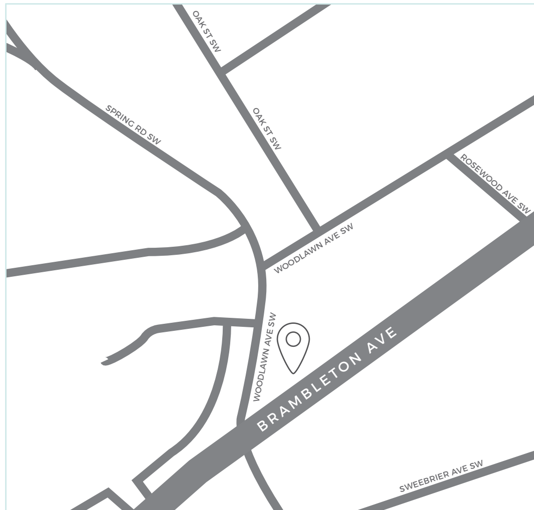
Date taken: __ /___ /___, E-mail Address:

Date of last FMX/panorex + BWX: : __ /___ /___

PERIODONTAL TREATMENT COMPLETED IN YOUR OFFICE:

- ❑ Plaque control instructions
- ❑ Scaling and Root Planing (Date: __ /___ /___)
- ❑ Prophylaxis and/or Gross Debridement
- ❑ Periodontal Maintenance Therapy

COMMENTS



PRIYA ACHARYA, D.M.D.

DIPLOMATE, AMERICAN BOARD OF PERIODONTOLOGY

2651 Brambleton Avenue
Roanoke, Virginia 24015
P: (540) 283-0959
F: (540) 765-4062
www.acharyaperiodontics.com
frontdesk@acharyaperiodontics.com