

## Patient Referral



**NOMITH T. RAMDEV, DMD, MSD**

Periodontics & Dental Implants

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Date \_\_\_\_\_ DOB \_\_\_\_\_

Introducing \_\_\_\_\_

Address \_\_\_\_\_

Phone # (H) \_\_\_\_\_ (W) \_\_\_\_\_

Please Evaluate:

General periodontal status \_\_\_\_\_

Periodontal status of \_\_\_\_\_

Soft tissue grafting \_\_\_\_\_

Crown lengthening of \_\_\_\_\_

Implant(s) \_\_\_\_\_

Bone grafting \_\_\_\_\_

TMJ/MPD symptoms \_\_\_\_\_

Please call patient \_\_\_\_\_

Patient will call you \_\_\_\_\_

What Future Treatment do you have planned?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Appointment \_\_\_\_\_  
Day \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

Dr. \_\_\_\_\_

*please print*

**If your office has multiple locations, please keep in mind when referring that if patients aren't in the same database to identify which location the patient is being referred from.**

Optional/additional comments:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Suggested radiographs needed for referral:

PA Date \_\_\_\_\_

FMX Date \_\_\_\_\_

Panorex Date \_\_\_\_\_

*Please do not send BWX's as we can't see apgx of tooth. PA's preferred for all except gen perio as FMX is needed to see entire mouth. No x-rays needed for STG.*

Enclosed

Will be mailed separately

Will accompany patient

X-rays will be emailed to:  
xrays@drramdev.com

To be taken at Dr. Ramdev's office and sent to referring doctor

Has this patient had quadrant root planning?

Yes \_\_\_\_\_ When \_\_\_\_\_

No \_\_\_\_\_

Thank you for entrusting your patient to us.

***Dr. Ramdev and Staff***

www.drramdev.com

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