



Referral Form for Deborah Hohn, D.D.S.
 Practice Limited to Periodontics and Implant Dentistry
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Active Member
 American Academy of Periodontology

I. DATE OF REFERRAL _____ REFERRED BY _____
 PATIENT'S NAME _____ DATE OF BIRTH _____
 TELEPHONE NUMBER _____ MEDICAL CONCERNS _____
 ALLERGIES _____ PRE-MED NEEDED _____

II. **PERIODONTAL REFERRAL:**
 ___ COMPLETE EXAM WITH SPECIAL ATTENTION TO _____
 ___ LIMITED EXAM (LIST TEETH NUMBERS) _____
 ___ Frenectomy _____ Mucogingival Problem _____
 ___ Crown Lengthening _____ Implant _____
 ___ Cuspid Exposure _____ Gingivectomy _____
 HAS SCALING AND ROOT PLANING BEEN COMPLETED?
 ___ YES DATE _____
 ___ NO
 RADIOGRAPHS:
 ___ BEING MAILED _____ GIVEN TO PATIENT
 ___ PLEASE TAKE _____ EMAILED
 DO YOU HAVE ANY RESTORATIVE PLANS? _____

III. **EXTRACTION RECOMMENDATIONS (PLEASE CIRCLE TEETH TO BE REMOVED)**

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
A B C D E								F G H I J							
T S R Q P								O N M L K							
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

IV. **IMPLANT REFERRAL:**
 PLEASE LIST YOUR DESIRED IMPLANT POSITION(S):

 DO YOU HAVE A SURGICAL TEMPLATE? _____ YES _____ NO
 IS AN INTERIUM PROSTHESIS MADE
 ___ NO ___ YES WHAT TYPE? _____
 DO YOU HAVE A SPECIFIC IMPLANT YOU WISH TO BE PLACED?
 ITI (STRAUMANN) _____
 BIOHORIZONS _____
 IMTEC (MINIS) _____
 OTHER _____

V. **OTHER PROCEDURES**
 ___ BIOPSY _____ I & D _____ RIDGE AUGMENTATION
 ___ ALVELOPLASY _____ SINUS AUGMENTATION
 ___ OTHER _____