

## Periodontology Referral Form

**Please send the form to:** Dr Bindhu Koshy (Specialist in Periodontics GDC Reg No: 83910), The Clock Dental Practice, 104 The Esplanade, Weymouth, DT4 7ED or email it to [theo.pelican@nhs.net](mailto:theo.pelican@nhs.net) , [www.clockdental.co.uk](http://www.clockdental.co.uk) , Tel : 01305 785 325

### PRACTICE DETAILS

<b>Referrer Name:</b>		<b>Date of Referral:</b>	
<b>Practice Address:</b>		<b>Tel:</b>	
<b>Postcode:</b>		<b>Fax:</b>	
<b>Email:</b>			
<b>Type of referral:</b>	<b>Routine</b> <input type="checkbox"/>	<b>Urgent</b> <input type="checkbox"/>	

### PATIENT DETAILS

<b>Name:</b>	<b>DOB:</b>	<b>Sex:</b> <b>Male</b> <input type="checkbox"/>	<b>Female</b> <input type="checkbox"/>
<b>Contact Address:</b>		<b>Tel (Home/Work/Mobile):</b>	
<b>Postcode:</b>			

<b>Medical History:</b>	<b>Smoking status:</b>					
	<b>BPE scores:</b> <table border="1" style="margin-left: auto; margin-right: auto; border-collapse: collapse;"> <tr> <td style="width: 33px; height: 33px;"></td> <td style="width: 33px; height: 33px;"></td> <td style="width: 33px; height: 33px;"></td> </tr> <tr> <td style="width: 33px; height: 33px;"></td> <td style="width: 33px; height: 33px;"></td> <td style="width: 33px; height: 33px;"></td> </tr> </table>					

<b>Reason for referral:</b>
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<b>PLEASE CONFIRM WHAT TREATMENT HAS BEEN PROVIDED:</b>			
Smoking Cessation Advice (if applicable)	<input type="checkbox"/>	Oral Health Education	<input type="checkbox"/>
Full Mouth Scaling and Subgingival Debridement	<input type="checkbox"/>	with Local Anaesthetic	<input type="checkbox"/>
<b>THIS REFERRAL INCLUDES</b>			
Relevant Radiographs	<input type="checkbox"/>	Periodontal Charts:	Pre-treatment <input type="checkbox"/> Post treatment <input type="checkbox"/>

<b>Signed:</b>	<b>Date:</b>
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