Holvin Louie, DDS, MS

Board-Certified Periodontist

REFERRAL FORM

Referring Doctor/Office: _____ **Date:** _____

Office Phone #: _____ **Email:** _____

Introducing Patient: _____ **Cell #:** _____

Reason(s) for Referral:

- ☐ Periodontal Evaluation
- ☐ Dental Implant Evaluation
- ☐ Periodontitis Treatment
- ☐ Crown Lengthening
- ☐ Other _____
- ☐ Bone Grafting
- ☐ Sinus Lift
- ☐ Gum Graft/Root Coverage
- ☐ Canine Exposure

Radiographs:

☐ X-rays sent with patient ☐ X-rays emailed to office (drlouie@louieperio.com) ☐ Patient needs x-rays

Comments: _____

_____

_____

THANK YOU FOR YOUR REFERRAL

We will maintain close communication with your office!

We are located in the same office as Little Penguin Pediatric Dentistry

Louie Periodontics/Little Penguin Pediatric Dentistry
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www.littlepenguindental.com