

# Fatima A. Tiwana, BDS, MSD

*Diplomate, American Board of Periodontology*

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15535 34th Ave N, Suite 200, Plymouth, MN 55447

Date \_\_\_\_\_

Patient Name \_\_\_\_\_

Phone \_\_\_\_\_

I am referring my patient to you for a periodontal evaluation of the following (marked) areas:

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16		
<b>RIGHT</b>																		<b>LEFT</b>
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17		

Remarks: \_\_\_\_\_

\_\_\_\_\_

Restorative/prosthetic treatment contemplated: \_\_\_\_\_

\_\_\_\_\_

Full mouth x-rays will be sent:  To the practice  With patient

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

Referring Doctor \_\_\_\_\_

Referring Practice \_\_\_\_\_

Email \_\_\_\_\_

Phone \_\_\_\_\_

Fax \_\_\_\_\_

