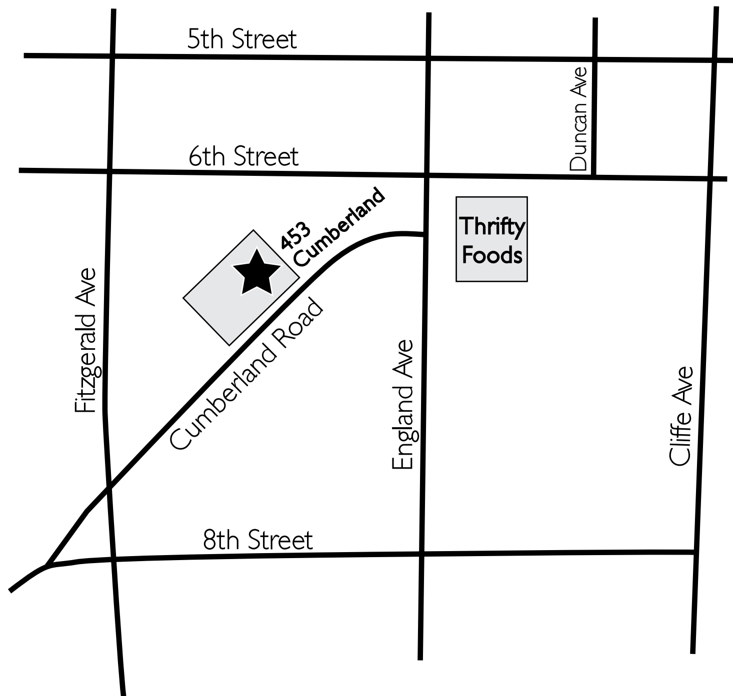
SARAH JOHNSTON DMD MS DIP PERIO FRCD C
453 Cumberland Road Courtenay BC V9N 2C5
PH 250 334 4480 FAX 250 334 4438 EMERGENCY PH 250 702 2602



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Referred By:

Dr. ____________________ Date ____________

Introducing:

Patient ____________________ D.O.B. DD / MM / YYYY

Address ____________________

Postal Code ____________ Telephone (Home) ____________

Telephone (Cell) ____________ (Business) ____________

Reason for Referral:

__Complete periodontal examination __ Specific periodontal examination

__Other: Specify ____________________

18 17 16 15 14 13 12 11	21 22 23 24 25 26 27 28
48 47 46 45 44 43 42 41	31 32 33 34 35 36 37 38

Comments: ____________________

History and Relevant Information:

(special medical conditions, allergies, prophylaxis requirements, dental considerations, restorative plan)

Appointment Status:

__Please call patient __ An appointment has been made __Patient will call

Radiographs (please send all current):

__Please take a new radiograph and remit copy __ Full month survey enclosed

__Radiograph of a specific area enclosed __ Please return radiographs after use