REFERRAL REQUEST

JUSTIN D. ZALEWSKY, DMD, MS
ANTARA DARU, DDS, MS

PRECISION
Periodontics and Implant Dentistry

2311 M Street, NW
Suite 500
Washington, DC 20037
202-296-3360

4660 Kenmore Avenue
Suite 300
Alexandria, VA 22304
703-823-2422

INFO@PRECISIONINPERIO.COM
WWW.PRECISIONINPERIO.COM

Referring Doctor_____ Date_____

Mr./Mrs./Ms./Dr._____

is being referred to you for periodontal examination.

Home Phone_____ Work Phone_____

THE FOLLOWING CONDITION(S) ARE OF CONCERN:

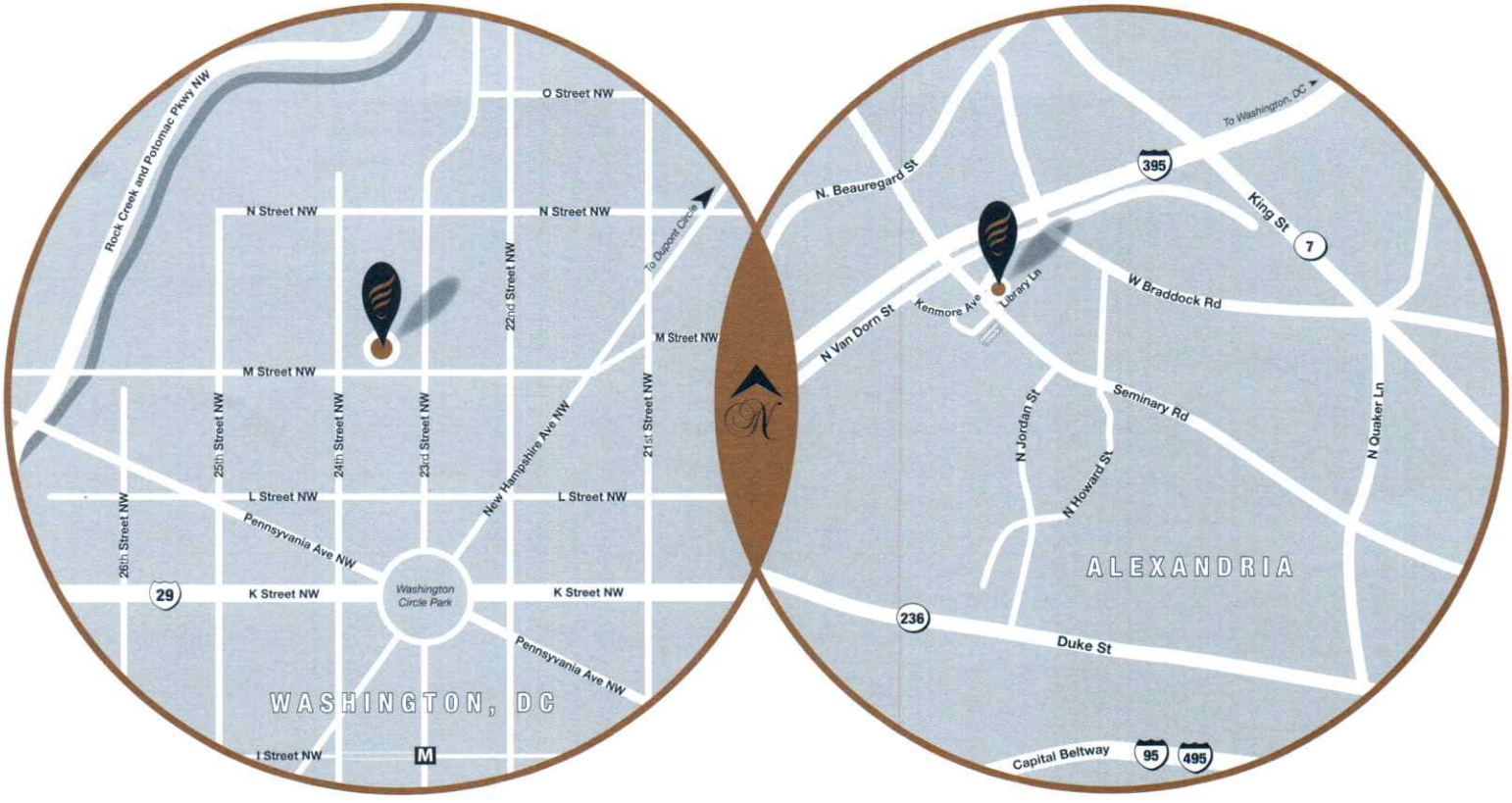
○ Generalized periodontitis_____
○ Localized periodontitis (teeth)_____
○ Mucogingival defect, recession (teeth)_____
○ Crown lengthening (teeth) _____
○ Edentulous ridge augmentation (area)_____
○ Extractions and ridge augmentation _____
○ Endosseous implant _____
○ Other condition_____

RADIOGRAPHS:

○ Full mouth radiographs are being sent with patient.
○ Full mouth radiographs are being mailed.
○ CBCT and evaluate.

COMMENTS:

_____
_____
_____
_____



2311 M Street, NW
Suite 500
Washington, DC 20037
202-296-3360

PRECISION
Periodontics and Implant Dentistry

4660 Kenmore Avenue
Suite 300
Alexandria, VA 22304
703-823-2422