REFERRAL TO: DR. McCLENAHAN

711 North McKinley Road, Lake Forest, IL 60045
(847) 234 -0600
755 S. Milwaukee Ave., # 120, Libertyville, IL, 60048
(847) 362-6650
Practice Limited to Periodontics and Implant Dentistry

FROM: DOCTOR____ DATE: __________________
PATIENT'S NAME: ____
PATIENT'S PHONE: HOME:_____________________________ WORK: _______________________
PATIENT OF RECORD IN YOUR OFFICE SINCE: MONTH:____________YEAR: ________________

TYPE OF REFERRAL:

___PATIENT HAS BEEN SENT TO YOU SPECIFICALLY FOR SURGERY.
___PATIENT HAS BEEN SENT TO YOU FOR CONSULT/TREATMENT SUGGESTIONS.
___PATIENT HAS BEEN SENT TO YOUR OFFICE FOR EXAMINATION/SECOND OPINION; PATIENT NOT CONVINCED OF PROBLEM
___PLEASE CALL REGARDING RECOMMENDATIONS PRIOR TO INITIATING TREATMENT.

PERIODONTAL TREATMENT SUGGESTED:

____
____
____

RESTORATIVE NEEDS:

_____COMPLETED / ________NEEDS
AMALGAM/COMPOSITE TEETH #S: ____
CROWNS TEETH #S: ____
BRIDGES TEETH #S: ____
IMPLANTS TEETH #S: ____
REMOVABLE PARTIAL DENTURE_____ MAXILLARY_____ MANDIBULAR_____
WILL TEMPORIZE PATIENT PRIOR TO SURGERY________
SPECIALIZATION INSTRUCTIONS/INFORMATION: ____
____
____
____

RADIOGRAPHS:

_________WE WILL SEND FMX/PA BEFORE TREATMENT
_________WE WILL GIVE FMX/PA TO PATIENT
_________PLEASE TAKE X-RAYS AND SEND US A COPY
_________FMX/PA ATTACHED

PATIENTS CONCERNS/FEARS/CHIEF COMPLAINT: ____
____
____

SINCERELY:____

Visit our new website www.NorthSuburbanPerio.com Please fax this form : 847-362-7902