Biddeford-Saco DENTAL ASSOCIATES

485 Main Street
Saco, ME 04072
207-282-9962
207-283-4299
sophie@bsda.com

PERIODONTAL REFERRAL / CASE REVIEW SHEET

For pre-review before the monthly periodontal visit | Submit through Practice-approved secure channel

Patient: _____ DOB: _____

Submitted by: _____ Date: _____

Tooth/area: _____ Provider/Hygienist: _____

Phone/EHR ID: _____ Urgency: ☐ Routine ☐ Time-sensitive

1. Referral Request

☐ Perio consult requested	☐ Surgical review requested
☐ Hygiene check requested during monthly visit	☐ Records review requested before scheduling

2. Reason for Review

☐ Pocketing / bone loss	☐ Furcation	☐ Mobility
☐ Recession / soft tissue	☐ Crown lengthening	☐ Extraction / socket graft
☐ Implant site	☐ Bone graft / GBR	☐ Sinus lift
☐ Peri-implantitis	☐ Implant All on X	☐ Other: _____

One-sentence summary: _____

3. Records Available

☐ Current medical history	☐ Medication/allergy list
☐ Perio chart, if perio concern	☐ PA / BW / FMX as applicable
☐ CBCT, if implant/graft/sinus/complex ext.	☐ Clinical photos, if soft tissue/esthetic/lesion
☐ Restorative plan, if implant or CLP	

4. Medical Alerts

☐ None known	☐ Diabetes
☐ Smoking/vaping/nicotine/marijuana	☐ Blood thinners
☐ Antiresorptive/antiangiogenic medication	☐ Immunosuppression
☐ Other: _____	

Prepared for use in connection with periodontal and implant services provided by Dr. Jeremy Kernitsky and/or Dr. Talin Mirzoyan at Biddeford Saco Dental Associates

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Perio Provider Decision

5. Perio Provider Decision

☐ Book surgery directly	Procedure: _____ Tooth/area: _____ Time block: ☐ Green 45 min ☐ Yellow 70 min ☐ Red 90+ min Materials needed: _____
☐ Need records first	Needed: _____
☐ Full perio consult	Time: ☐ 45 min ☐ 60 min Reason: _____
☐ GP/restorative first	Reason: _____
☐ Monitor / no treatment now	Follow-up: _____

Provider notes _____

_____

_____

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