ROBERT S. GUIER, D.D.S.

PERIODONTICS
& Implant Dentistry

"Reshaping a Quality of Life Through a Commitment to Excellence"

REFERRAL FAX (no cover sheet required) (318)798-1202

Referring Dr.: ____

Patient's Name:____ DOB:________________________

Phone Numbers: (H)________________________(W)________________________C)________________________

Reason for Referral:

- ☐ **Dental Implants:** T#'s ____
- ☐ **Periodontal**
  - ☐ Full Mouth Evaluation
  - ☐ Isolated Areas — Area of teeth in question
    - ☐ Isolated Pockets ________________________________
    - ☐ Mucogingival Defects (gingival recession) ________________________________
    - ☐ Crown Lengthening ________________________________
    - ☐ Other ________________________________
- ☐ **Radiographs**
  - ☐PA's ☐FMX ☐Panorex
  - ☐ To be emailed (guierperio@gmail.com)
  - ☐ Dr. Guier's office will take

☐Study Models
(requested for implant cases)

Comments:

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