Periodontics

Drs. McClain and Schallhorn, P.C.

Specialty Referral Form

TO:	Drs. McClain and Schallhorn, P.C.	FROM:	
FAX:	(303) 696-1958	FAX:	
PHONE:	(303) 696-7885	PHONE:	

Referring Doctor: _____ **Date:** _____

Patient Name: _____ **Phone Number:** _____

Reason for referral (select all that apply):

- ☐ **Comprehensive periodontal exam**
- ☐ **Implant / extraction, area:**
- ☐ **Recession, area:**
- ☐ **Mucogingival, area:**
- ☐ **Crown lengthening, area:**
- ☐ **Cosmetic periodontal procedure, area:**
- ☐ **Other:**

X-rays: ☐ **Available** ☐ **Please take as needed**

Projected Restorative/Other Treatment:

Comments:

Diplomates, American Board of Periodontology
Pamela K. McClain, D.D.S. - Rachel A. Schallhorn, D.D.S., M.S. - Robert G. Schallhorn, D.D.S., M.S.
11200 East Mississippi Ave, Aurora, Colorado 80012 | Phone: (303) 696-7885 | Fax: (303) 696-1958 | www. periocolorado.com.com