Daniel B. Stiefel, D.M.D., Board Certified Periodontist

Practice Limited to Periodontics and Implant Therapy

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Referral information:

Referring Doctor:________________________________

Patient's Name:________________________________

Date of Referral:________________________________

Please provide the following service(s) for my patient:

[ ] Complete Periodontal Evaluation

[ ] Limited Periodontal Evaluation on tooth # ___ or UR / UL / LR / LL quadrant(s)

[ ] Pocket Elimination/Reduction for Pocketing in the: UR / UL / LR / LL quadrant(s)

[ ] Crown Lengthening on tooth #___

[ ] Soft Tissue Graft on tooth #___

[ ] Implant therapy for tooth #___

Important details about my patient:

1) Radiographs:

[ ] My patient is bringing them from my office to CHP
[ ] Sent by mail to CHP
[ ] Emailed to CHP
[ ] Please take any necessary radiographs and send a copy to my office

2) Please perform scaling and root planing? Yes / No

3) After active periodontal therapy, please coordinate the following treatment schedule:

[ ] My patient should return to my office as soon as condition is stabilized
[ ] My office and CHP will share the hygiene schedule
[ ] My patient should return to CHP for yearly checkups

4) For implants, will the patient have a surgical stent to guide the placement? Yes / No

Additional details and/or comments:

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