Dear Dr. ____________________________

For your records the chart below summarizes the treatment rendered. Thank you for your continuing confidence.

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☐ Consultation ☐ Extraction ☐ Root Amputation
☐ Emergency Treatment ☐ Free Soft Tissue Graft ☐ Hemisection
☐ Biopsy ☐ Pedicle Soft Tissue Graft ☐ Osseous Graft
☐ Occlusal Adjustment ☐ Frenectomy/Fiberotomy ☐ Bite Guard
☐ Oral Hygiene Instruction ☐ Gingivectomy ☐ Hawley Type
☐ Scaling/Root Planing ☐ Modified Widman Flap ☐ Full Occlusal
☐ Local Anesthesia ☐ Flap and Osseous Surgery ☐ Implant
☐ Intravenous Sedation ☐ Alveoloplasty ☐ Placement
☐ Curettage ☐ Distal Wedge ☐ Exposure
☐ Additional Appointments scheduled
  We will notify you upon completion
☐ Maintenance and Periodontal Prophylaxis ☐ Radiographs enclosed
  ☐ Oral Hygiene/Plaque Control is ☐ Good ☐ Fair ☐ Poor
  ☐ Sulci are within physiologic limits
  ☐ Progress is satisfactory, periodontal health is being maintained.
  ☐ Progress is unsatisfactory, the following areas show regression
    ☐ We will attempt to correct/maintain by conservative management/surgery.
☐ Caries noted # ____________________________________________________________
☐ Patient is being returned to your office for maintenance at __________ month intervals.
  We will monitor the patient’s status in ___________ months.
☐ We will continue periodontal maintenance for you patient unless you advise otherwise
  However, please continue to examine the patient regularly for other dental needs.
☐ The patient requested that we perform recalls at our office.
☐ We should alternate periodontal maintenance at __________ month intervals.

**Patient advised** ☐ to contact your office ☐ your office will call

Other ________________________________________________________________

If you have any questions please call. Regards, ____________________________
Form B

YOUR OFFICE HEADER

ACTIVE PERIODONTAL THERAPY COMPLETION REPORT

TO: Doctor ________________  RE: Patient ________________  DATE: _________________

We have completed the active phase of periodontal therapy on your patient. An examination to evaluate your patient’s overall response to therapy was performed. A summary of the clinical findings and proposed maintenance care are detailed below for inclusion in your patient’s records:

- **1. Initial Therapy:**
  - Oral Hygiene Instruction
  - Root planning and Cruettage
  - Occlusal Adjustment
- **2. Mucogingival-Osseous Surgery**
- **3. Gingivoplasty**
- **4. Frenectomy**
- **5. Gingival Grafting**
- **6. Osseous Grafting**
- **7. Osseointegrated Implants (by referral)**
- **8. Guided Tissue Regeneration**
- **9. Other ____________________________**

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B. **PROGNOSIS**
- **1. Hopeless**
- **2. Questionable**
- **3. Fair**
- **4. Other ____________________________**

C. **MAINTENANCE CARE**
- **1. May we suggest placing your patient on alternating recall every _______ months, following their first periodontal maintenance visit with you/us in ________________ months.**
- **2. We are returning your patient to your for maintenance care.**
- **3. Your patient’s first recall with your office will be ____________________________**
- **4. Due to poor response to therapy and the presence of deep residual pockets, we would like to suggest that the patient’s initial periodontal maintenance be reformed in our office. Please schedule your patient for periodic restorative evaluation at appropriate interval.**
- **5. We will take necessary radiographs to evaluate residual osseous support. Copies will be sent to you for your records.**

D. Your patient was informed of the need for a consultation with you concerning ____________________________

E. **COMMENTS AND CONCERNS:** ____________________________
Please contact me if you have any questions or comments concerning this patient’s treatment.

Form C

TREATMENT LETTER
YOUR OFFICE HEADER

Date ____________________________

Dear Dr. ________________________________

I saw your patient ______________________________ on ______________ for an evaluation after completing active periodontal therapy. At this time oral hygiene and periodontal probing depths were reevaluated.

TREATMENT TO DATE
☐ oral hygiene instruction
☐ periodontal scaling and root planning under local anesthesia
  - UR ☐ LR ☐ UL ☐ LL
☐ periodontal surgery
  - UR ☐ LR ☐ UL ☐ LL
☐ implants ____________________________________________
☐ GTR
☐ microbial testing
☐ controlled release fiber
☐ Other ____________________________________________

PRESENT LEVEL OF ORAL HYGIENE

1 2 3 4 5 6 7 8 9 10
Poor Excellent

PROGNOSIS

Short Term Long Term
☐ Good ________________________ ☐ Good ________________________
☐ Fair _________________________ ☐ Fair _________________________
☐ Guarded ____________________ ☐ Guarded ____________________
☐ Poor ________________________ ☐ Poor ________________________
☐ Hopeless ____________________ ☐ Hopeless ____________________

RECOMMENDATIONS PRESENTED TO PATIENT
☐ maintenance therapy at ____________ month intervals
  ☐ alternating between our offices
  ☐ at your office
  ☐ at my office
☐ the patient’s next maintenance visit is to be at __________ office ______________________
  ☐ the patient has been scheduled for an appointment on ______________________
  ☐ the patient need to be contacted to schedule an appointment.
Dear Dr. ______________________________ Date: ________________________

Our mutual patient ________________________________ was seen recently in our office. The patient was treated with the following procedures at that time and may require some special attention.

____ A regenerative procedure which may include non-resorbable or resorbable material was placed in ______________________________. This/these areas should not be probed on instrumented for 6 months.

____ Was tested for oral pathogens on ______________________________. The areas tested were ______________________________. As a result of test findings, ______________________________ was prescribed for __________________ days. We are anticipating a marked decrease in disease activity. If nothing to the contrary please notify our office.

____ Antibiotic (fiber or gel) was placed in ______________________________. We are expecting tissue health to improve in that area. Please advise us if you note otherwise.

Thank you for your continued help in monitoring our mutual patient’s periodontal health.
PATIENT INACTIVATION REPORT
YOUR OFFICE HEADER

Date __________________________________

Dear Dr. ________________________________

Re: ________________________________

The above patient has been placed in our “Inactive Patient File”.

☐ We have been unable to schedule the patient for an appointment.

☐ The patient no longer wants treatment at this office and is being referred back to your office for comprehensive dental treatment.

☐ The patient has not accepted our recommended treatment plan and wished to return to your office for comprehensive dental care. The patient has been advised of the possible sequelae of not having recommended treatment performed and needed of having periodontal treatment.

☐ Treatment has been completed and the patient wishes maintenance cleaning to be performed at your office.

COMMENTS __________________________________________________________

________________________________________________________________________

________________________________________________________________________

Thank you for your confidence in us by referring your patient to our office. If there is anything further we can do for this patient please call.

Sincerely,

________________________________________________________

☐ cc: copy sent to patient