COLLECTIVE HEALTH SOCIETY
HEALTHY MOUTH. HEALTHY BODY.

# Patient Referral Form

## Patient Information:

| | | |
|---|---|---|
| Full Name | : | |
| Date of Birth | : | |
| Gender | : | |
| Email | : | |
| Phone Number | : | |

## Reason for Referral:

(Check all that apply)

- ☐ Bleeding gums / Periodontal symptoms
- ☐ Elevated inflammatory markers (e.g., hsCRP)
- ☐ Autoimmune conditions (RA, Lupus, etc.)
- ☐ Fertility concerns or pregnancy
- ☐ Cardiac history or stroke risk
- ☐ Diabetes or metabolic issues
- ☐ GI symptoms or gut dysbiosis
- ☐ Cognitive decline / Family history of dementia
- ☐ Airway concerns
- ☐ Salivary testing
- ☐ Other: _____

## Provider Notes (optional):

## Referring Provider:

| | | |
|---|---|---|
| Name | : | |
| Practice Name | : | |
| Phone | : | |
| Email | : | |

**Please email this completed form to: patients@collectivehealthsociety.com**