

## Dental Referral

Referral to Dentist	
Today's Date:	<input type="checkbox"/> Routine Referral <input type="checkbox"/> Immediate Referral
Referring Practice:	Referring Provider:
Referring Provider Fax:	Referring Provider Phone:
Patient name:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F DOB:
Parent/guardian Name: _____ Relationship to child: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other _____ Best phone number: _____ Primary language: <input type="checkbox"/> English <input type="checkbox"/> Other Interpreter needed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Insurance: <input type="checkbox"/> Medicaid ID# _____ <input type="checkbox"/> Other insurance _____ <input type="checkbox"/> Dental insurance _____ <input type="checkbox"/> None/Self-pay
Significant medical history:	There are factors that could hinder performing an oral exam, x-rays and/or dental treatment. <input type="checkbox"/> No <input type="checkbox"/> Yes (explain)
This child has allergies: <input type="checkbox"/> No <input type="checkbox"/> Yes (please list)	Date of last fluoride varnish application: _____ Fluoride supplement prescribed: <input type="checkbox"/> Yes <input type="checkbox"/> No
I am the parent/guardian for this child. I consent to this medical provider sharing information about my child with the dentist/dental practice named below. I also consent to the dentist sharing information about my child with this medical provider.	Signature: _____ Date: _____
Dentist/Dental Practice Name:	Phone: _____ Fax: _____
Dental Report to Medical Provider	
Date of appointment(s):	
Treatment provided: <input type="checkbox"/> Oral hygiene instruction <input type="checkbox"/> Prophylaxis <input type="checkbox"/> Fluoride treatment	<input type="checkbox"/> Restorative care: <input type="checkbox"/> Extractions: <input type="checkbox"/> Other:
Summary:	Practice Name and address:
Dentist name:	Dentist signature:  Date: