from the first tooth
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DENTAL REFERRAL FORM
FOR MEDICAL PROVIDERS

MEDICAL PROVIDER REFERRAL TO DENTIST

Today's Date	Reason for Referral: _____ ☐ Routine Referral ☐ Immediate Referral		
Referring Practice	Referring Provider		
Referring Provider Fax	Referring Provider Phone		
Patient Name	M F	DOB:	
Parent/Guardian Name_____ Relationship to Child ☐ **Mother** ☐ **Father** ☐ **Other**_____ Best Phone Number(s) to Call _____ Primary Language: ☐ English ☐ Other: _____ Interpreter needed? Y N	Insurance: ☐ **Medicaid ID#:** _____ ☐ **Other Insurance:** _____ ☐ **Dental Insurance:** _____ ☐ **None/Self-Pay**		
Significant medical history:	There are factors that could hinder performing an oral exam,x-rays and/or dental treatment for this child. ☐ No ☐ Yes Explain:		
This child has allergies: ☐ No ☐ Yes List:	Date of last fluoride varnish application(s): _____ Fluoride supplements prescribed: ☐ No ☐ Yes		
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 THE MEDICAL PROVIDER

Date of Dental Appointment(s):		
Treatment Provided: ☐ Oral Hygiene Instructions ☐ Prophylaxis ☐ Fluoride Treatment ☐ Fluoride Prescription ☐ Restorative Treatment: ☐ Extractions: ☐ Other: _____		
Summary Statement		
Practice Name & Address		
Dentist Name	Dentist Signature	Date

Adapted from the Maine Oral Health Risk Assessment and Referral Tool – Primary Care