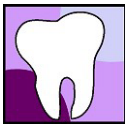
Medical Provider Referral to Dentist



Medical Provider:

(1) Complete this section (2) Copy for your records (3) Send copy to dental office
(4) Ask parent/guardian to take this form to a child's dental appointment.

Patient's Name | DOB | Referral Date

Medical Provider's Name | Phone | Address, Fax or E-mail

Dental Provider's Name | Phone | Address, Fax or E-mail

Reason for Referral: routine ☐ age 1 ☐

suspected problem:

Any Medical Precautions for Dental Treatment:

no ☐ yes ☐

explain:

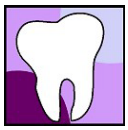
ALERT: taking medications ☐ has allergies ☐

Oral Health Care Given by this Medical Provider:

fluoride Rx ☐ OR recommended drinking fluoridated water ☐

fluoride varnish ☐ recommended brushing with fluoride toothpaste ☐

Dental Report to Medical Provider



Dental Provider:

(1) Complete this section (2) Copy for your records (3) Mail, fax or e-mail form to medical provider

Treatment Provided:

oral hygiene instructions ☐ prophy ☐ restorative tx ☐ sealants ☐

fluoride RX ☐ fluoride varnish/topical fluoride ☐

Comments:

tx completed ☐ additional tx needed ☐

Dental Provider's Name | Date