Patient Referral Form

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Referring Doctor

Doctor Name:

Clinic Name:

Clinic Phone Number:

Date of referral: (day / month / year)

Patient Information

Patient Full Name:

Gender: ☐ Male ☐ Female Age:

Date of Birth: (day / month / year)

Parent/Guardian Name:

Relation to Patient:

Phone number:

E-mail:

Address:

Insurance information:

Company

Certificate #

Group #

Reason for Referral

☐ **Patient needs a pediatric dental home**
Patient needs pediatric specialty care due to age or level of cooperation. Patient will be referred back to your office when specialist care is no longer required

☐ **Specific procedure needed**
Please specify procedure(s) below. Patient will be referred back to your office following completion of the requested procedure(s).

☐ **Urgent Referral**
Patient requires an urgent appointment. Patients seen within 5-10 business days of referral.

☐ **EMERGENCY**
True dental emergency. Patient seen on same day the referral is received. **Please specify nature of emergency below.**

Comments and other relevant dental and medical history

Appointment Scheduling

☐ Please contact patient to schedule appointment

☐ Patient will contact your office to schedule appointment

☐ Patient already has an appointment booked at your office

Radiographs

☐ None available

☐ E-mailed. Date taken:

☐ Our office requires more referral pads

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