

# Pediatric medical-to-dental care referral form

## Patient Information

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Parent/Guardian: \_\_\_\_\_ Height: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Weight: \_\_\_\_\_

## Medical Professional Information

Pediatric Care Professional: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Signature: \_\_\_\_\_

## Follow-Up Request

This patient is being referred for a dental evaluation and care in a dental home. If this patient requires sedated care, please contact our office to discuss next steps. Until this child can be seen regularly by a dental professional, our office will provide periodic oral health screenings, oral hygiene guidance, and fluoride varnish/supplementation as needed. *Please indicate if this child was seen in your office by faxing our office a short note with information regarding the visit and a follow-up plan. Thank you.*

## Referral Information for Dental Professional

Reason for Referral:  Immediate care needed  Abnormal oral screening  Routine dental care  
 Other, please describe

Concerns: \_\_\_\_\_

Describe conditions that could affect their receipt of routine or restorative dental care that could require anesthesia:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Known Allergies: \_\_\_\_\_

(continued on back)

**Medications Patient is Currently Taking:**

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**Significant Medical Conditions:**  None  Yes (specify)

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**Teeth Present:**  None  Yes

**Oral Exam Findings:**  Good oral health  White spots or obvious dental caries  Gingivitis

Other, please describe

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**Notes:**

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**Does someone brush the child's teeth daily?**  Yes  No  Don't know

**Does the child use toothpaste with fluoride?**  Yes  No  Don't know

**Does the child go to bed with a bottle or cup?**  Yes  No  Don't know

**Was fluoride varnish applied?**  Yes, Date \_\_\_\_\_  No  Don't know

**Were fluoride supplements prescribed?**  Yes, Date \_\_\_\_\_  No  Don't know

**Other oral health concerns:**

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## Dental Professional Information

This child has been referred to

Dental Professional Name: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Questions about how to pay for dental care? Call your dental benefits professional or get information about coverage at [insurekidsnow.gov](http://insurekidsnow.gov) or by calling 2-1-1.**

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