

## Patient Referral Form – Physician to Dentist

Patient name: \_\_\_\_\_

Daytime phone: \_\_\_\_\_

Referral date: \_\_\_\_\_

**Patient referred by:**

Dr. \_\_\_\_\_

Office phone: \_\_\_\_\_

**Patient referred to:**

Dr. \_\_\_\_\_

- Patient has appointment on: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_
- Patient will call and schedule an appointment.

This patient is undergoing treatment or therapy for the disease entities indicated. Since the disease(s) could have dental implications, this patient is being referred for comprehensive oral assessment and dental treatment, if necessary.

- |  |  |
|--|--|
| <input type="checkbox"/> Diabetes mellitus   | <input type="checkbox"/> Kidney dialysis                 |
| <input type="checkbox"/> Joint replacement   | <input type="checkbox"/> Organ transplant                |
| <input type="checkbox"/> Head and neck radiation   | <input type="checkbox"/> Pregnancy                       |
| <input type="checkbox"/> Bisphosphonate therapy  | <input type="checkbox"/> Chemotherapy                    |
| <input type="checkbox"/> Cardiovascular disease (hypertension, stroke, myocardial infarction, other) | <input type="checkbox"/> Gastroesophageal reflux disease |
|  | <input type="checkbox"/> Other _____                     |

Current medications:

_____	_____
_____	_____
_____	_____

Current medical status (e.g., most recent BP, HgA1c):

\_\_\_\_\_

Past or current tobacco use, alcohol use: \_\_\_\_\_

**Dentist's findings and recommendations:**

- Patient's oral and periodontal health is within normal parameters.
- Patient requires priority oral or dental treatment within a specified time frame for completion of care prior to medical therapy. List specific treatment needs.
- \_\_\_\_\_
- \_\_\_\_\_
- Patient needs emergency oral care to allow urgent medical systemic care to occur faster. List specific treatment needs.
- \_\_\_\_\_
- \_\_\_\_\_
- Treatment of oral disease can be performed concurrently with systemic treatment.

Note: There is no guarantee that recommended treatment is a covered benefit.

Dentist signature: \_\_\_\_\_ Date evaluation completed: \_\_\_\_\_

**Patient: Please return form to referring physician.**