Primary Care Clinic Name/Logo DATE:_____
Address/Phone/Fax

DENTAL REFERRAL FORM

PATIENT NAME: _____ MRN# _____

REFERRED TO: _____ Phone_____ Fax_____

REFERRED BY: _____ Phone_____ Fax_____

REASON FOR REFERRAL (be specific please):
_____
_____
_____
_____

Primary Care Oral Assessment (PCOAT) risk category: ( ) Moderate ( ) High ( ) Extreme

Current Oral Therapies/Management (i.e. antibiotic, analgesia, etc.):
_____
_____
_____
_____

Oral Procedures Completed:
Fluoride Varnish/Date: _____
_____ /Date: _____

Attached:
( ) Patient demographics (Name, DOB, address, phone #, insurance)
( ) Patient clinical information (allergies, medications, medical diagnosis, chief complaint)
( ) Primary Care Oral Assessment

jem_02/282016