

Referral for Medical Care (Adult)

From: Dr. [Name] DDS/DMD
 Practice Name (if applicable)
 Street Address
 City, state, zip
 telephone/fax number
 Email address

To: Dr. [Name] MD/DO
 Street Address
 City, state, zip
 telephone/fax number
 Email address

Date:	<input type="checkbox"/> Urgent Care <input type="checkbox"/> Routine Care
We are referring:	Patient Name: Birth Date: Gender: Address: Telephone: Home: Work: Cell: Language spoken at home: <input type="checkbox"/> English <input type="checkbox"/> Other Preferred Language:
Appointment:	<input type="checkbox"/> Appointment scheduled on _____ at _____ AM/PM <input type="checkbox"/> Patient will call for appointment
Reason for Referral <i>(Check all that apply.)</i>	<input type="checkbox"/> Medical evaluation related to the following (prior to dental treatment) <input type="checkbox"/> coagulation issues <input type="checkbox"/> respiratory issues <input type="checkbox"/> risk of seizures <input type="checkbox"/> anesthesia tolerance <input type="checkbox"/> risk of CV incident <input type="checkbox"/> other <input type="checkbox"/> Signs/Symptoms of disease/condition Describe: <input type="checkbox"/> Evaluation of allergic reaction to: <input type="checkbox"/> Routine medical care: <input type="checkbox"/> Other:
Relevant History: <i>(Check all that apply.)</i>	<input type="checkbox"/> Dental Problems: <input type="checkbox"/> periodontal disease <input type="checkbox"/> cavities (caries) <input type="checkbox"/> other: <input type="checkbox"/> Special Health Care Needs: <input type="checkbox"/> Medications: <input type="checkbox"/> Other:
Preferred Follow Up:	<input type="checkbox"/> Written or Faxed Report <input type="checkbox"/> None necessary

Referred by: _____ (Print name)
 _____ Signature

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