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

Referred by: _____ (Print name)

_____ Signature

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