# Referral for Medical Care (Child)

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:<br>Birth Date:<br>Gender:<br>Parent/Guardian Name:<br>Address:<br>Telephone: Home: Work: Cell:<br>Language spoken at home:<br>☐ English ☐ Other Preferred Language: |
| Appointment: | ☐ Appointment scheduled on at AM/PM<br>☐ Parent/guardian will call for appointment |
| Reason for Referral<br>*(Check all that apply.)* | ☐ Medical consultation prior to dental treatment<br>☐ Immunization record<br>☐ Evaluation for systemic disease<br>☐ Evaluation of allergic reaction to:<br>☐ Establish medical home; routine medical care:<br>☐ Other: |
| Relevant History:<br>*(Check all that apply.)* | ☐ Known Allergies:<br>☐ Dental Problems:<br>☐ Special Health Care Needs:<br>☐ Medications:<br>☐ Other: |
| Preferred Follow Up: | ☐ Written or Faxed Report<br>☐ None necessary |

Referred by: _____ (Print name)

_____ Signature



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