

## 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:   | <input type="checkbox"/> Urgent Care <input type="checkbox"/> 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><input type="checkbox"/> English <input type="checkbox"/> Other    Preferred Language:  |
| Appointment:  | <input type="checkbox"/> Appointment scheduled on _____ at _____ AM/PM<br><input type="checkbox"/> Parent/guardian will call for appointment   |
| Reason for Referral<br><i>(Check all that apply.)</i> | <input type="checkbox"/> Medical consultation prior to dental treatment<br><input type="checkbox"/> Immunization record<br><input type="checkbox"/> Evaluation for systemic disease<br><input type="checkbox"/> Evaluation of allergic reaction to:<br><input type="checkbox"/> Establish medical home; routine medical care:<br><input type="checkbox"/> Other: |
| Relevant History:<br><i>(Check all that apply.)</i>   | <input type="checkbox"/> Known Allergies:<br><input type="checkbox"/> Dental Problems:<br><input type="checkbox"/> Special Health Care Needs:<br><input type="checkbox"/> Medications:<br><input type="checkbox"/> Other:  |
| Preferred Follow Up:                                  | <input type="checkbox"/> Written or Faxed Report<br><input type="checkbox"/> None necessary  |

Referred by: \_\_\_\_\_ (Print name)  
 \_\_\_\_\_ Signature

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