



## Patient Referral Form

### PRIORITY OF SERVICE

☐ Routine ☐ Urgent

**Urgent Certification:** By circling urgent, I certify the presence of true dental urgency, including severe swelling, pain, infection, or other emergency situations that would jeopardize the life or health of the patient.

Date \_\_\_\_\_ Patient Name \_\_\_\_\_ Medical ID \_\_\_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_

Parent/Guardian/Caregiver Name \_\_\_\_\_ Home # \_\_\_\_\_ Work # \_\_\_\_\_

PCD Name \_\_\_\_\_ Office Phone \_\_\_\_\_

Office Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_

### Specialty – Please select appropriate specialty and attach required supporting documentation:

#### ☐ Oral Surgery

- ☐ PA of tooth
- ☐ PANO-multi exts/3rds
- ☐ Medical history
- ☐ Perio charting
- ☐ Chart notes

#### ☐ Periodontics

- ☐ FMX
- ☐ PA – 1 area
- ☐ Medical history
- ☐ Chart notes

#### ☐ Endodontics

- ☐ PA of tooth
- ☐ Medical history
- ☐ Restorative Plan
- ☐ Chart notes

#### ☐ Prosthodontics

- ☐ Pano/FMX
- ☐ Medical history
- ☐ Perio charting
- ☐ Chart notes

#### ☐ Peds

- ☐ X-rays
- ☐ Chart notes
- ☐ Medical history
- ☐ Chart notes

CDT/ADA Code(s) \_\_\_\_\_

Clinical findings and Diagnosis \_\_\_\_\_

Restorative treatment plan (please note that if final restoration is not covered, benefit referral will be denied) \_\_\_\_\_

Prognosis \_\_\_\_\_ Special instructions \_\_\_\_\_

Height and weight (for GA or sedation referrals) \_\_\_\_\_

Sedation Indicated? ☐ Yes ☐ No Please describe indication for sedation: \_\_\_\_\_

PCD Signature \_\_\_\_\_ Date \_\_\_\_\_

### For use by CDC Staff Only

Referred to: \_\_\_\_\_

Address: \_\_\_\_\_

City/State: \_\_\_\_\_

Zip Code: \_\_\_\_\_

Office Phone #: \_\_\_\_\_

Valid From: \_\_\_\_\_ to: \_\_\_\_\_

Referral #: \_\_\_\_\_

