CAPITOL DENTAL CARE, INC.

Patient Referral Form

Today's Date: ____________ Valid From: ____________ To: ____________ Ref #: ____________________

Note: *Referral number is only for the purpose of transferring the patient to the referring provider.*

Type of specialty referral requested:

Limited/Specific Treatment ☐ Ongoing Treatment ☐

Please select appropriate specialty and supporting documentation available.

OS	Perio	Endo	Prosth	Pedo
☐ PAX of tooth	☐ FMX	☐ PAX of tooth	☐ Pano/FMX	☐ X-rays
☐ Pano multi exts/3rds	☐ PAX – 1 area	☐ Med HX	☐ Pre-Auth	☐ Chart notes
☐ Sedation-consent	☐ Charting	☐ Rest. Plan	☐ Completed	
☐ Med Comp HX	☐ Hygiene HX-Rest		☐ Perio charting	
☐ Dentures (partial)	☐ Med Comp HX			

Patient Name: ______________________________ **Medical ID #:** ______________**DOB:** ____________

Address: ______________________________ City/State: ____________________ Zip: ____________

Parent/Guardian Name: ______________________________ Home #: ______________ Work #: ______________

PCD: ______________________________ **Phone:** ______________________________

Address: ______________________________ City/State: ____________________ Zip: ____________

Reason for the referral and Special instructions -be *very* specific. ______________________________

____

Diagnosis/Clinical Findings: ______________________________

____

Treatment Plan/ Prognosis: ______________________________

____

____

Sedation Requested: Yes ☐ No ☐ If yes, you must include ***clinical need*** for sedation: ______________________________

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PCD Signature: ______________________________

Date: ______________________________

For Use By CDC Staff Only:

Referred To: ______________________________

Address: ______________________________

City/State ______________________________

Zip Code: ______________________________

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CDC Dental Director Comments:

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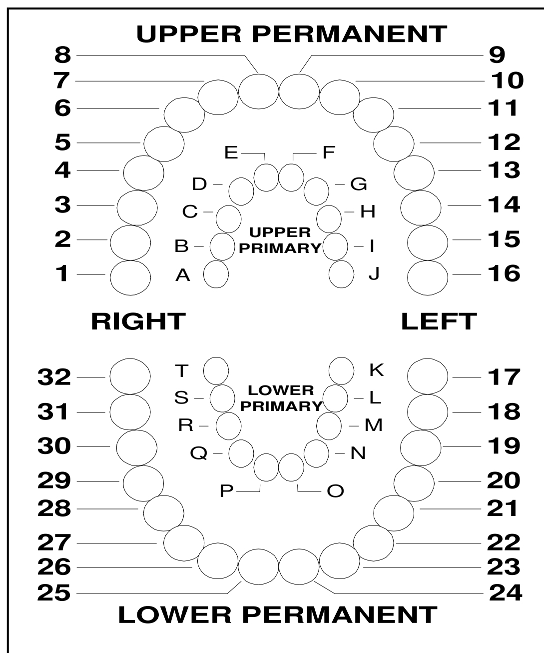
Sedation Denied: ☐ Call for Approval: ☐

Sedation Approved: GA ☐ IV ☐



Please place an **"X"** on tooth numbers that need treatment.

Revised 4/13/17