

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.

PLEASE ATTACH CHART NOTES WITH ANY TYPE OF REQUEST

OS

- PAX of tooth
- Pano multi exts/3rds
- Sedation-consent
- Med Comp HX
- Dentures (partial)

Perio

- FMX
- PAX - 1 area
- Charting
- Hygiene HX-Rest
- Med Comp HX

Endo

- PAX of tooth
- Med HX
- Rest. Plan

Prosth

- Pano/FMX
- Pre-Auth
- Completed
- Perio charting

Pedo

- X-rays
- Chart notes

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: _____

PCD Signature: _____

Date: _____

For Use By CDC Staff Only:

Referred To: _____

Address: _____

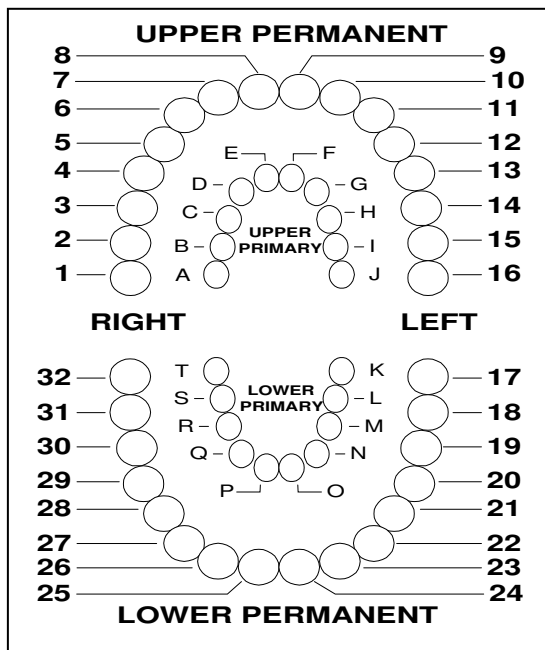
City/State: _____

Zip Code: _____

CDC Dental Director Comments:

Sedation Denied: **Call for Approval:**

Sedation Approved: **GA** **IV**



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