BlueDental℠
Part of a *complete* health plan

Patient Referral Form — **Dentist to Physician**

Patient name:	**Daytime phone:**	**Referral date:**
Patient referred by:		**Office phone:**
Patient referred to:		
Dental treatment planned:		
☐ Patient has appointment on: Date: _____ Time: _____ ☐ Patient will call and schedule an appointment.		

During a recent oral and maxillofacial examination, we were alerted to the possibility of this patient having a positive medical history or signs and symptoms of the following:

- ☐ Diabetes mellitus
- ☐ Joint replacement
- ☐ Head and neck radiation
- ☐ Bisphosphonate therapy
- ☐ Cardiovascular disease (hypertension, stroke, myocardial infarction, other)
- ☐ Kidney dialysis
- ☐ Organ transplant
- ☐ Bleeding disorder
- ☐ High Blood Pressure Readings
- ☐ Pregnancy
- ☐ Chemotherapy
- ☐ Gastroesophageal reflux disease
- ☐ Other: _____

We are referring this patient to you for a thorough medical evaluation and are requesting any additional medical information to assist us in managing the patient when he or she undergoes dental treatment.

Contraindications to the planned procedures based on your physical findings or the patient's medical history (please indicate all of this patient's diagnoses):	
Physician signature: **WHEN COMPLETED**	Date evaluation completed:

Note: There is no guarantee that recommended treatment is a covered benefit.

We will delay dental procedures, pending your written recommendations. Thank you for your efforts on behalf of this patient.

Physician: Please fax or email this form to referring dentist.