BlueDental℠
Part of a *complete* health plan

Patient Referral Form – **Dentist to Physician**

Patient name: _____

Daytime phone: _____ **Referral date:** _____

Patient referred by:

Dr. ____ _____ Office phone: _____

Patient referred to:

Dr. ____ _____

☐ 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
☐ 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.

Dental treatment planned:

Contraindications to the planned procedures based on your physical findings or the patient's medical history (please indicate all of this patient's diagnoses):

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 signature: **WHEN COMPLETED** _____ Date evaluation completed: _____

Patient: Please return form to referring dentist.

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