BlueDental[SM]

Part of a *complete* health plan

Patient Referral Form – **Physician to Dentist**

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.

This patient is undergoing treatment or therapy for the disease entities indicated. Since the disease(s) could have dental implications, this patient is being referred for comprehensive oral assessment and dental treatment, if necessary.

- ☐ 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_______________________

Current medications:

____ ____ _________________________________
____ ____ _________________________________
____ ____ _________________________________

Current medical status (e.g., most recent BP, HgA1c):

____

Past or current tobacco use, alcohol use: ____

Dentist's findings and recommendations:

- ☐ Patient's oral and periodontal health is within normal parameters.
- ☐ Patient requires priority oral or dental treatment within a specified time frame for completion of care prior to medical therapy. List specific treatment needs.
  ____
  ____
- ☐ Patient needs emergency oral care to allow urgent medical systemic care to occur faster. List specific treatment needs.
  ____
  ____
- ☐ Treatment of oral disease can be performed concurrently with systemic treatment.

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

Dentist signature: _____________________________ Date evaluation completed: ________________

Patient: Please return form to referring physician.