Dental Referral Form

Date:______/_____/__________

Patient Name:____

Parent/Guardian:____

Telephone: (_________)-__________-__________________

DOB:___________/___________/________________

Medi-Cal #: ___________________________________

Referring Provider:____

Telephone: (_________)-__________-__________________

Reason for Referral (select one):

[ ] Patient Request [ ] Problem Focused Exam [ ] Patient Needs Preventative Treatment

[ ] Other (Please Specify in Notes)

Notes/Relevant History:

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Additional Follow-up Instructions:

[ ] Please Report Back to PCP **[ ] No Follow-up Needed**

- **Written**
- **By Phone**

Please Fax this form to (909) 581-6669

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(909) 987-9933