BlueDental℠
Part of a *complete* health plan

Patient Referral Form — **Physician to Dentist**

Patient name:	**Daytime phone:**	**Referral date:**
Patient referred by:		**Office phone:**
Patient referred to:		
☐ 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
- ☐ Cancer (kind and location) _____
- ☐ Chemotherapy
- ☐ Gastroesophageal reflux disease
- ☐ Other: _____

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

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: **WHEN COMPLETED**	Date evaluation completed:

Dentist: Please fax or email form to referring physician.