ARCHER DENTAL

Advancing dental care in our changing world

Referral Form

Patient Information

Patient's Last Name _____ First Name _____ Middle Name _____

□ Dr. □ Mr □ Mrs □ Miss □ Ms

□ Regulary in wheelchair
□ stretcher/ bed
□ Uses walker/ ambulates

Contact Information

Contact Name _____ Relationship to Patient _____ Home Phone Number _____ Work Phone Number _____

Referring Clinician

Dentist Name _____

Dentist Phone Number _____

Dentist Fax Number _____

Physician _____

Physician Phone Number _____

Physician Fax Number _____

Dental X-Rays □ Yes □ No □ Mailed □ Sent to Patient

Type □ PAN □ PA's

Date Taken _____

Reason for Referral: _____

_____

Medical/Dental Information:

Does Patient have any allergies (penicillin, latex, certain foods, other? □ Yes □ No

Is the patient taking anticoagulants? If taking Coumadin, please bring last 3 INR results or 1st consultation □ Yes □ No

Is Antibiotic prophylaxis required for dental treatment? □ Yes □ No

Please list any prescription or non-prescription drugs: _____

_____

_____

Please list relevant Medical History: _____

_____

_____

Any other Comments: _____

_____

_____ _____

Signature Date: