## Oral Health Patient Consultation/Referral Form

### Patient Information

<table>
<thead>
<tr>
<th>First Name</th>
<th>Middle Initial</th>
<th>Last Name</th>
</tr>
</thead>
</table>

Mailing Address, City, State, ZIP

<table>
<thead>
<tr>
<th>Phone Number</th>
<th>Email Address</th>
</tr>
</thead>
</table>

Consult Requested By (Medical Provider): 

**Date**

<table>
<thead>
<tr>
<th>Office Phone Number</th>
<th>Office Fax Number</th>
<th>Office Email Address</th>
</tr>
</thead>
</table>

### Oral Health Evaluation Request

**Dear Dental Colleague:** Please evaluate this patient and provide any information that will assist us in providing medical care as described below. Medical treatment may be delayed pending your written recommendations. Thank you for your prompt return of this consult.

- [ ] Patient scheduled for medical consult: 
  - **Appointment Date**
  - **Appointment Time**

- [ ] Patient will call to schedule an appointment

**Reason for evaluation:**

- [ ] Dental pain or swelling
- [ ] Dental trauma
- [ ] Lost or defective restoration
- [ ] Evidence of dental decay
- [ ] Impacted teeth/partially erupted teeth
- [ ] Suspect periodontal disease
- [ ] Other:

  - [ ] Oral pathology/biopsy
  - [ ] Missing teeth
  - [ ] Needs dentures
  - [ ] Cancer/radiation treatment
  - [ ] Cardiovascular surgery
  - [ ] Transplant

**The patient presents with the following medical diagnoses (problem list):**

1.  
2.  
3.  
4.  
5.  
6.  
7.  
8.  
9.  

**Medications:**

1.  
2.  
3.  
4.  
5.  
6.  
7.  
8.  
9.  

**Medical treatment planned:**

[ ]

**Provider Signature**  
**Date**

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Please complete dental evaluation on the reverse of this form
# Patient Authorization to Release Medical Information

I hereby authorize release of my health information to the medical office requesting this consultation.

<table>
<thead>
<tr>
<th>Patient Signature</th>
<th>Date</th>
</tr>
</thead>
</table>

## Oral Health Evaluation Report

### Evaluation findings:

### Dental issues related to proposed treatment:

### Recommendations/treatment plan:

<table>
<thead>
<tr>
<th>Evaluation Completed By (print)</th>
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<table>
<thead>
<tr>
<th>Office Phone Number</th>
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<table>
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<tr>
<th>Dentist Signature</th>
<th>Date</th>
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