

SPOKANE DISTRICT DENTAL SOCIETY FOUNDATION

General Dentist Request for Referral/Consultation

Patient Name: _____ DOB: _____ Gender: M F

Interpreter Needed: Y N Language: _____ Phone: _____

Date of Referral: _____ Referring Dentist: _____

Specialty Requested: _____

Working Diagnosis: _____

Reason for Referral: _____
(symptoms) _____

Date of Onset of Current Problem/Symptoms: _____

Exam/Treatment to Date (please attach pertinent records) _____

Diagnostic Testing: X-rays Enclosed Yes No

Co-morbidities: Alcoholic Smokes Diabetic Cardiac Disease

Consult only Evaluate and Treat Evaluate/Treat/Surgery if indicated

What specific questions do you want answered by the consultant? _____

Who do you want to manage the patient's medications? Primary Care Specialist

Send information to: _____

Signature of Referring Dentist for Project Dental Access

Date of Referral

Treatment/Follow-up Recommendations: _____

Signature of Project Dental Access Provider

Date