HUDSON
ORAL HEALTH

Patient Referral Checklist

Date: _____

Patient Name: _____ **Referring Doctor:** _____

Patient Contact Info: _____

Chief Concern:

What is the primary reason for referral of this patient?:

_____

_____

What treatment has previously been performed in this area (please list dates, type, materials, providers)

_____

_____

What is the history of their current condition? (Progressing recession, fractured tooth, caries risk etc.)

_____

Does the patient have pain? ☐ YES ☐ NO Does the patient have swelling? ☐ YES ☐ NO

Interim treatment as provided by referring doctor:

Medications prescribed with date: _____

Provisional restoration/appliance: _____

Other: _____

Do medical concerns exist? ☐ YES ☐ NO Has a physician been consulted? ☐ YES ☐ NO

Documentation Available:

☐ Photographs ☐ Diagnostic casts ☐ Periodontal charting ☐ Type of Radiographs _____

Other/Comments: _____

Proposed Treatment Plan:

What is your proposed treatment plan?

_____

_____

Coordination with Interdisciplinary Team Doctors:

Have any other doctors been consulted regarding this treatment plan? ☐ YES ☐ NO

Please list: _____

_____

Additional Comments:

_____

_____

_____