FIDELIS CARE®

Pediatric medical-to-dental care referral form

Patient Information

Patient Name: _____ DOB: ___ / ___ / _____

Parent/Guardian: _____ Height: _____

Telephone: _____ Weight: _____

Medical Professional Information

Pediatric Care Professional: _____ Date: ___ / ___ / _____

Telephone: _____ Fax: _____

Signature: _____

Follow-Up Request

This patient is being referred for a dental evaluation and care in a dental home. If this patient requires sedated care, please contact our office to discuss next steps. Until this child can be seen regularly by a dental professional, our office will provide periodic oral health screenings, oral hygiene guidance, and fluoride varnish/supplementation as needed. *Please indicate if this child was seen in your office by faxing our office a short note with information regarding the visit and a follow-up plan. Thank you.*

Referral Information for Dental Professional

Reason for Referral: ☐ Immediate care needed ☐ Abnormal oral screening ☐ Routine dental care

☐ Other, please describe

_____

Concerns: _____

Describe conditions that could affect their receipt of routine or restorative dental care that could require anesthesia:

_____

_____

_____

Known Allergies: _____

(continued on back)

PRO_42538E State Approved 09122019

Medications Patient is Currently Taking:

_____

Significant Medical Conditions: ☐ None ☐ Yes (specify)

_____

Teeth Present: ☐ None ☐ Yes

Oral Exam Findings: ☐ Good oral health ☐ White spots or obvious dental caries ☐ Gingivitis

☐ Other, please describe

_____

Notes:

_____

Does someone brush the child's teeth daily? ☐ Yes ☐ No ☐ Don't know

Does the child use toothpaste with fluoride? ☐ Yes ☐ No ☐ Don't know

Does the child go to bed with a bottle or cup? ☐ Yes ☐ No ☐ Don't know

Was fluoride varnish applied? ☐ Yes, Date _____ ☐ No ☐ Don't know

Were fluoride supplements prescribed? ☐ Yes, Date _____ ☐ No ☐ Don't know

Other oral health concerns:

_____

Dental Professional Information

This child has been referred to

Dental Professional Name: _____

Telephone: _____ Fax: _____

Questions about how to pay for dental care? Call your dental benefits professional or get information about coverage at insurekidsnow.gov or by calling 2-1-1.

 This poster is supported by the Grant or Cooperative Agreement Number, [6 NU38OT000167-04-01], funded by the Centers for Disease Control and Prevention (CDC). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the CDC or the Department of Health and Human Services. The American Academy of Pediatric Dentistry, American College of Obstetricians and Gynecologists, American Dental Association, and the American Dental Hygienists' Association support the value of this clinical document as an educational tool, April 2019.

ACOG The American College of Obstetricians and Gynecologists

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN®