FIDELIS CARE®

Medical Provider Referral to Dentist

COMPLETED BY MEDICAL PROVIDER ONLY

Instructions:

1. Complete this section.
2. Copy for your records.
3. Send copy to dental office.
4. Ask parent/guardian to take this form to a child's dental appointment.

Referral Date: _____

Patient's Name: _____ Date of Birth: _____

Medical Provider's Name: _____ Phone: _____

Address: _____

City, State & ZIP code: _____

Fax: _____ E-mail: _____

Dental Provider's Name: _____ Phone: _____

Address: _____

City, State & ZIP code: _____

Fax: _____ E-mail: _____

Reason for Referral: ☐ Age 1 ☐ Routine ☐ Emergency

Suspected Problem: _____

Any Medical Precautions for Dental Treatment: ☐ Yes ☐ No

Explain: _____

Alert: Please list if any of the following is applicable.

☐ Taking Medications: _____

☐ Has Allergies: _____

Oral Health Care given by this provider:

☐ Fluoride Rx ☐ Recommended drinking fluoride water

☐ Fluoride Varnish ☐ Recommended brushing with fluoride toothpaste

(continued)

PRO_20524E Internal Approved 08292018

Dental Report to Medical Provider

COMPLETED BY DENTIST ONLY

Dental Provider: _____ Date: _____

Instructions:

1. Complete this section.
2. Copy for your records.
3. Mail, fax or e-mail form to medical provider.

☐ Oral hygiene ☐ Cleaning ☐ Restorative tx ☐ Exam/X-rays
☐ Sealants ☐ Fluoride Rx ☐ Fluoride Varnish/Topical Fluoride

Comments: _____

☐ tx completed ☐ Additional tx needed Approx. # of units needed: _____