

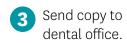
Medical Provider Referral to Dentist

COMPLETED BY MEDICAL PROVIDER ONLY

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A	Complete
	this section.

2	Copy for
	your records



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	e:	Phone:	
Address:			
Fax:		E-mail:	
Dental Provider's Name:	:	Phone:	
Address:			
Fax:		E-mail:	
	Age 1 Routine Emergency		
•	s for Dental Treatment: Yes No		
	of the following is applicable. s:		
Has Allergies:			
Oral Health Care given b	by this provider:		
☐ Fluoride Rx	☐ Recommended drinking fluoride v	vater	
☐ Fluoride Varnish	☐ Recommended brushing with fluo	ride toothpaste	
			(continued)

1-888-453-2534 (TTY: 711) fideliscarenj.com **(?**

Dental Report to Medical Provider

COMPLETED BY DENTIST ONLY

Dental Provider: _	Date:
Instructions:	
Complete this section	Copy for your records. 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: