Capitol Dental

Patient Referral Form

Date_____ Valid From _____ To _____ Referral #_____

Specialty – Please select appropriate specialty and attach required supporting documentation:

☐ **Oral Surgery**	☐ **Periodontics**	☐ **Endodontics**	☐ **Prosthodontics**	☐ **Pedo**
☐ PA of tooth	☐ FMX	☐ PA of tooth	☐ Pano/FMX	☐ X-rays
☐ PANO-multi exts/3rds	☐ PA – 1 area	☐ Medical history	☐ Medical history	☐ Chart notes
☐ Medical history	☐ Medical history	☐ Restorative Plan	☐ Perio charting	☐ Medical history
☐ Perio charting	☐ Chart notes	☐ Chart notes	☐ Chart notes	☐ Chart notes
☐ Chart notes				

Patient Name _____ Medical ID_____ DOB _____

Address_____ City/State_____ Zip _____

Parent/Guardian/Caregiver Name_____ Home #_____ Work # _____

PCD Name_____ Office Phone _____

Office Address_____ City/State_____ Zip _____

Referral Type (please select one): ☐ Limited for specific treatment ☐ Ongoing

Type of referral requested_____ CDT/ADA Code(s) _____

Clinical findings and Diagnosis_____

_____

Restorative treatment plan (please note that if final restoration is not covered, benefit referral will be denied)_____

_____

Prognosis _____

Special instructions (such as allergies, premed, prosthetic delivery) _____

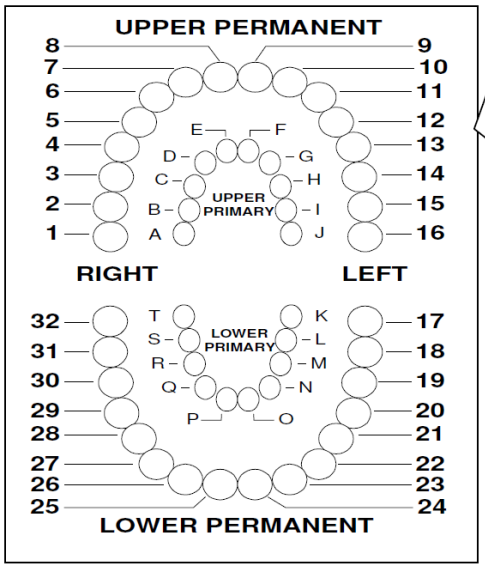
Height and weight (for GA or sedation referrals) _____

Sedation Indicated? ☐ Yes ☐No Please describe indication for sedation: _____

PCD Signature_____ Date_____

For Use By CDC Staff Only:

Referred To: _____
Address: _____
City/State _____
Zip Code: _____



Please place an **"X"** on tooth numbers that need treatment.

Revised 5/11/2023