**Referral form for use by community dentists when referring patients to Children's Hospital Colorado's Dental Center**

**Referral from**

**Practice/clinic name** _____ **Date** _____

**Address** _____

**Referring dentist's name** _____

**Best phone number to reach the provider making this referral** _____

Please print clearly so we know where to send our report.

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**Referral to**

Children's Hospital Colorado

**Department of Pediatric Dentistry – Health Pavilion - 2nd Floor**

Attn. Referral Coordinator

**Physical address:** 860 N. Potomac Cir., Aurora, CO 80011

☎ 720-777-6788 **Fax:** (720) 777-7239

**Email:** dentaladmin@childrenscolorado.org

Please email us the patient's dental x-rays.

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**We are referring patient** _____ **DOB** _____

**Parent/Guardian name** _____

**Best contact ☎ number** _____

**Insurance** (if applicable) _____

**Group/Medicaid #** _____

**Last dental cleaning** _____

**Please** note that we provide only services related to pediatric dentistry (**no molar endo or asymptomatic 3rd molar removal**). Additionally, we do not perform oral maxillofacial surgery or endodontics. Thank you!

**Reason for Referral** (please be specific or fax/email progress notes)

_____

_____

Does this family have expectations for conscious sedation, general anesthesia, or any other special care circumstances? □ Yes □ No

Have you already discussed any of these options with the child's parents or caregivers? □ Yes □ No

Do you want this patient to return to your office after completion of his/her immediate needs? □ Yes □ No

**Relevant Medical/Dental History; History of Present Illness**

_____

_____

**Treatment provided by referring dentist** (please include the dates of service and email any radiographs that you have taken)

□ Comprehensive Exam □ Limited Exam □ Antibiotics □ Radiographs □ Fluoride □ Prophylaxis

_____

_____

_____

_____ _____ _____

Signature of dentist who provided treatment Print name Date