REFERRAL FORM

Please Fax this Form to: (312) 996-1981
or Email to dentpediatrics@uic.edu

Patient Name ________________________________________ Age__________
Phone: Home (   ) ____________________ Work (   ) ____________________
Parent’s Name: _____________________________________________
Special Health Concerns: ______________________________________
________________________________________________________________________

Reason for referral:
☐ Pain
☐ Trauma
☐ Special Needs
☐ Rampant Caries
☐ Behavior/Age
☐ Extractions
☐ Pathology
☐ Sedation
☐ General Anesthesia
☐ Interceptive orthodontic treatment
☐ Other:________________________
________________________________________________________________________

Referring Doctor information
☐ X-rays Given to Parent  ☐ X-rays mailed/E-mailed  ☐ Needs X-rays
Referring Doctor: ___________________________ Phone: ____________________
Doctor’s Email address: ___________________________
Today’s Date: ________________________________