DENTAL REFERRAL TREATMENT REPORT

PATIENT INFORMATION:	Patient Name:	DOB:		Phone: Fax: Email:
	Address:			

DENTAL CARE REPORT:	Date of Dental Appt:	List any prescription agents given to patient:		Is all needed treatment completed? □ Yes □ No
	Patient's Oral Health Diagnosis: 　　□ **Abscess/Infection [K12.2]** □ Periodontitis [K05.6] 　　□ Caries Activity/Decay [K02.9] □ Gingivitis [K05.1] 　　□ Other: _____			
	Self-Management Goal Recommendations:			
	Date of Patient's Next Dental Appointment: _____/_____/_____	Additional Notation:		

DENTAL CARE TEAM:	Date: _____/_____/_____	Dental Provider:	Dental Provider Phone #:
	Dental Provider Signature:		