Sample Referral Form used with diabetic patients:

Your Community HEALTH SERVICES, Inc.

MEDICAL/ DENTAL DIABETES REFERRAL (Sample Form)

Patient name: _____ Date of birth:_____
Last First

Medical Account Number: _____

Do you have a dentist? YES NO

Have you seen a dentist in the last year? YES NO

For routine exam and cleaning? YES NO

For emergency care or pain relief? YES NO

Do you have loose or painful teeth? YES NO

Do your gums bleed when you brush or floss? YES NO

Do you have bad breath? YES NO

Type Diabetes 1 2

HbA1c=

Allergy to Doxycycline Yes No

REFERRING PHYSICIAN:_____ Date:_____

**FORWARD/FAX THIS FORM to _____AT _____ Dental Clinic.

FAX #:

Source: Jacqueline A. Tallman, RDH, MPA
Dental Director Health Disparities Collaborative
National Network for Oral Health Access
Michigan Primary Care Association
jtallman@mpca.net