NSDA DENTAL REFERRAL FORM FOR PEDIATRIC PATIENTS **DEC 2025**

To: _____ **From**: _____

_____ _____

☐ Certified Specialist in Pediatric Dentistry

☐ General Practice Dentist accepting referrals of children

We are referring:

Patient: _____ Birthdate: _____

Parent/Guardian _____

Telephone: H_____W_____ C_____

Address: _____

HEALTH CARD NUMBER _____ **Province** _____

Medical History:

Allergies Y / N _____

Medical Conditions Y / N

☐ Bleeding Disorder ☐ Diabetes/Hypothyroid

☐ Respiratory/Asthma ☐ Obese (mild/moderate/severe)

☐ Cardiac Condition, If Yes, specify_____

☐ Immune Deficiency, If Yes, specify _____

☐ Autism/Developmental Delay/ADHD/ODD

☐ Neuromuscular (Cerebral Palsy/Muscular Dystrophy)

☐ Other, If Yes, specify_____

Medication Y / N Rx / OTC: _____

Caries Y / N List: _____

_____

Trauma Y / N Location/Teeth involved: _____

Pain Y / N ☐ Stimulated ☐ Spontaneous ☐ Nocturnal

Pain Medication: (type/frequency/duration) _____

Infection Y / N ☐ Extra-oral (Cellulitis) ☐ Intra-oral (Parulis / Fistula / Abscess)

Location: _____

Antibiotics Y/N (type/frequency/duration)_____

Pathology Y / N Location / Description: _____

Orthodontic Extraction Y / N Extract Teeth #: _____

Orthodontic Consult Conducted Y / N Letter Enclosed Y/N

Has treatment been attempted Y/N Details (When/Where/Name of Dentist/Management Modality):

_____

☐ Radiographs Enclosed

Additional Information _____

_____

By referring this patient to your practice, I acknowledge that this patient is not currently awaiting treatment by another practitioner.

Dentist: _____ **Signature**: _____ **Date**: _____