NSDA DENTAL REFERRAL FORM FOR PEDIATRIC PATIENTS

To: ______________________________________ **From**: ____________________________________

______________________________________ ____________________________________

☐ Certified Specialist in Paediatric Dentistry

☐ General Practice Dentist accepting referrals of children

We are referring:

Patient: _________________________________ Birthdate: ___________________________________

Parent/Guardian ____

Telephone: H________________________W_____________________ C_____________________________

Address: ____

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: ____

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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):

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☐ Radiographs Enclosed

Additional Information ____

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

Dentist: ___________________________ **Signature**: ___________________________ **Date**: ______________