REFERRAL FORM

Please Fax this Form to: (312) 413-3400 or Email to dentpeditodirics@uic.edu

Patient Name ___________________________________________ Age________________
Phone: Home ( ) ___________________ Work ( ) ___________________________
Parent’s Name: __________________________________________________________________
Special Health Concerns: __________________________________________________________________
Patient INSURANCE information (including plan): ______________________________________

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: ___________________________