

RECEIVING OFFICE

Dental ERx PLLC

St. Francis Bartlett Medical Arts Pavilion
2996 Kate Bond Rd, Suite 311 | Bartlett, TN 38133
(901) 445-0788
Fax: (901) 445-0789

HOW TO REFER

1. Complete all sections of this form.
2. Email referrals@dentalerx.com.
3. Attach relevant radiographs / records.
4. Patient may walk in or call to schedule.
5. Urgent cases: call (901) 445-0788 first.

PATIENT INFORMATION

Last Name First Name Date of Birth Phone

Address Insurance / Member ID Chart # Date of Visit

REFERRING PROVIDER

Provider Name Practice / Office Name Phone / Fax Email

Date of Referral

REFERRAL FOR

<input type="checkbox"/> Comprehensive Exam	<input type="checkbox"/> Limited / Emergency Exam	<input type="checkbox"/> X-Rays / Radiographs	<input type="checkbox"/> Cleaning / Prophylaxis
<input type="checkbox"/> Root Canal Therapy (RCT)	<input type="checkbox"/> Extraction	<input type="checkbox"/> Surgical Extraction / Impacted	<input type="checkbox"/> Filling / Restoration
<input type="checkbox"/> Crown / Bridge	<input type="checkbox"/> Implant Consultation	<input type="checkbox"/> Periodontal Treatment	<input type="checkbox"/> Oral Surgery Consult
<input type="checkbox"/> Oral Health Clearance — Surgery Tooth / Teeth #(s) <input type="text"/>	<input type="checkbox"/> Oral Health Clearance — Military Urgency <input type="text"/>	<input type="checkbox"/> Oral Health Clearance — Medical Appt Needed Within <input type="text"/>	<input type="checkbox"/> Other (see notes below) Referred To (Provider / Dept) <input type="text"/>

CLINICAL NOTES / REASON FOR REFERRAL

RELEVANT HISTORY & ATTACHMENTS

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Cardiovascular disease	<input type="checkbox"/> Blood thinners / anticoagulants	<input type="checkbox"/> Antibiotic prophylaxis required
<input type="checkbox"/> Drug / latex allergy Allergies / Medications of Note <input type="text"/>	<input type="checkbox"/> Bisphosphonate use	<input type="checkbox"/> Immunocompromised Radiographs Enclosed? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Radiation — head / neck
		Photos Enclosed? <input type="checkbox"/> Yes <input type="checkbox"/> No	

SIGNATURE

Authorized Signature Date