DENTAL REFERRAL TREATMENT REPORT

PATIENT INFORMATION:	Patient Name:	DOB:	Phone: Fax: Email:
	Address:		
DENTAL CARE REPORT:	Date of Dental Appt:	Did patient keep their scheduled appointment? □ Yes □ No	Is all needed treatment completed? □ Yes □ No
	List any prescription agents given to patient:		
	Patient's Oral Health Diagnosis: □ **Abscess/Infection [K12.2]** □ Periodontitis [K05.6] □ Caries Activity/Decay [K02.9] □ Gingivitis [K05.1] □ Other: _____		
	Self-Management Goal Recommendations:		
	Date of Patient's Next Dental Appointment: _____/_____/_____	Additional Notation:	
DENTAL CARE TEAM:	Date: _____/_____/_____	Dental Provider:	Dental Provider Phone #:
	Dental Provider Signature:		