
# DENTAL HEALTH NETWORK

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## Dental Treatment Referral

Date:

Child's Name: Date of Birth:

Special Needs: ❑ YES ❑ NO

Name of School:

Parent's Name:

Address:

Phone #:

Insurance: ❑ Private ❑ Medi Cal ❑ None

Name of Referring Nurse:

Nurse's Email Address:

School District:

Nurse's Phone #:

Reason for Referral:

Anterior Decay? ❑ Yes ❑ No # of Cavities

Posterior Decay? ❑ Yes ❑ No # of Cavities

Infection Present? ❑ Yes ❑ No # of Cavities

Pain Involved? ❑ Yes ❑ No # of Cavities

Comments:

*For office use only*

Date File Closed: # of calls: Chart #: