THE CENTER FOR PEDIATRIC DENTISTRY
UNIVERSITY of WASHINGTON
School of Dentistry

6222 NE 74th Street Seattle, WA 98115
Phone: 206-543-5800 Fax 206-543-0063

Email: cpdreferral@uw.edu*
http://thecenterforpediatricdentistry.com

HIPAA requires using encrypted email pathways when emailing patient information.

*Please refer to our referral email policy

ALL THE FOLLOWING FIELDS ARE REQUIRED INFORMATION

Referral will be sent back if not filled out completely

Referral Date:______________________ **Is this an urgent concern?** ☐ **Y** ☐ **N**

Patient Name:____ **Reason for Urgency:**________________

Date of Birth:______________________ **Sex:**__________ **Preferred Pronoun (if known)**________________

Parent/Guardian Name:____

Contact Phone Number(s):____

Is an Interpreter Needed? ☐ **Y** ☐ **N** **Language:**____

DENTAL REASON FOR REFERRAL:

☐ **GA/Sedation** ☐ **Consult/Limited Exam** ☐ **Transfer of Care**

Treatment needs: **(please be as specific as you can)**

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Are there any special medical needs? **None** ☐

☐ **Wheelchair** ☐ **GTube** ☐ **Asthma** ☐ **Obesity - BMI Percentile**_________ ☐ **Other**

Please provide any current diagnosis and relevant medical history

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Are there any behavioral concerns? **None** ☐

☐ **Autism** ☐ **ADHD** ☐ **Dental Anxiety** ☐ **Previous Failed Dental Treatment** ☐ **Other**

Please explain:

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Last recall date __________ **Pediatrician** ________________________ **Last Medical Exam** _____________

Does the patient have X-Rays? ☐ **Y** ☐ **N If yes, what type and date taken?**_________________________

X-Rays sent by (check one): ☐ **Email (cpdreferral@uw.edu)** ☐ **Given to parents**

Referring Provider, Clinic Name, and Phone Number:

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