UNIVERSITY of WASHINGTON

the center for pediatric dentistry
Washington Dental Service Building
In Partnership with Seattle Children's

206-543-5800 • www.thecenterforpediatricdentistry.com

If you have questions or problems in completing this referral form please call 206-543-5800.

Referral Form

Date of Referral:

Patient Name: Date of Birth:

Parent or Guardian Name:

Address:

Home Phone: Cell Phone:

Work Phone:

☐ Interpreter Needed? Language:

Please *email or fax us this form at:
cpdreferral@uw.edu or 206-543-0063

6222 NE 74th Street
Seattle, WA 98115

Phone: 206-543-5800
FAX: 206-543-0063
thecenterforpediatricdentistry.com

Requested Consultation/Treatment

- ☐ Consultation
- ☐ Comprehensive Care
- ☐ Establish Dental Home
- ☐ Consultation and Limited Treatment
- ☐ Return to Referring Dentist
- ☐ Treatment is Medically Necessary

Special Instructions

- ☐ Special Needs
- ☐ Rampant Caries
- ☐ Medical Concerns, specify
- ☐ Dental Concerns, specify
- ☐ Oral Surgery (Under age 12)

Comments

____
____
____
____

We have these Radiographs

- [ ] Bitewings
- [ ] Periapical tooth #'s ____ ____ ____ ____ ____
- [ ] Panoramic
- [ ] Other, specify ______________________________
- [ ] None

- [ ] We will send the above listed radiographs by date: ______________
  - [ ] *Electronically to cpdreferral@uw.edu
  - [ ] US Mail

- [ ] Parent/Patient has been given radiographs and will bring them to the appointment.

Referring Provider: Clinic:

Address:

City: State:

Zip: Phone:

Return this referral form to us by:

1) Printing completed form and faxing to us at 206-543-0063 or

2) Printing completed form, scanning into a PDF and sending it to us *electronically at cpdreferral@uw.edu or

3) Printing blank form, manually filling out fields, and emailing or faxing to us.

Thank you for your referral

*Please consult our referral email policy.