

*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: _____

Requested Consultation/Treatment

Consultation

Consultation and Limited Treatment

Comprehensive Care

Return to Referring Dentist

Establish Dental Home

Treatment is Medically Necessary

Special Instructions

Special Needs

Rampant Caries

Medical Concerns, specify

Dental Concerns, specify

Comments

W
UNIVERSITY of
WASHINGTON

the
center
for
**pediatric
dentistry**

Washington Dental Service Building
In Partnership with Seattle Children's

206-543-5800 • www.thecenterforpediatricdentistry.com

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

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](#).