FLORIDA DEPARTMENT OF HEALTH IN POLK COUNTY
DENTAL REFERRAL

PART I – CLIENT INFORMATION

Client Name: _____ Date of Birth: _____

Address: _____ City : _____ Zip Code: _____

Home Phone: ( ) - _____ Mobile Phone: ( ) - _____

Best time to call: ☐ AM ☐ PM Language Preference: ☐ English ☐ Spanish ☐ Haitian Creole

LIP approved client? ☐ **YES** ☐ **NO** ☐ **Don't know**

If you answered "**YES**" to above question please provide Last Eligibility Determination Date: _____,

Primary medical provider name: _____,

Phone: ( ) - _____ Fax : ( ) - _____

Name of Employer: _____

Income: $ _____ Frequency: ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Annually

*Monthly Unearned income: $*_____ ☐ *Alimony* ☐ *Child Support* ☐ *Public Assistance* ☐ *SSA*
☐ *Workers Comp* ☐ *Unemployment* ☐ *Other:* _____

PART II– REFERRING ORGANIZATION OR CLINIC

☐ DOH OB/GYN ☐ LRMC Family Health Center ☐ Peace River Center ☐ School Health
☐ DOH Adult Health ☐ LVIM ☐ Polk Healthcare Plan ☐ WIC
☐ DOH Pediatrics ☐ Parkview ☐ Polk Workforce
☐ DOH Speciality Care ☐ PCSB Head Start ☐ Other: _____

Referring Organization or Clinic **fax number**: ( ) - _____

		YES	NO
1.	Established DOH client?	☐	☐
2.	Have you attached the most recent health assessment, medication list, and allergies?	☐	☐
3.	Is this patient on anticoagulants?	☐	☐
4.	Ryan White referrals, have you attached the most recent labs?	☐	☐
5.	OB patients, is she cleared for local anesthesia? ☐ **Yes**, with epinephrine. ☐ **Yes**, w/o epinephrine		☐
6.	OB patients, is she approved for x-ray with shielding?	☐	☐
7.	OB patients, is she approved for Antibiotics?	☐	☐
8.	OB patients, is she approved for Pain Medications?	☐	☐
9.	Please list any other special Medical Considerations: _____		

PART III – DENTAL CLINIC FOLLOW UP

1st call attempt:	☐ Appointment Made	☐ No Answer	☐ Left Message	☐ Disconnected	☐ Wrong Number
2nd call attempt:	☐ Appointment Made	☐ No Answer	☐ Left Message	☐ Disconnected	
3rd call attempt:	☐ Appointment Made	☐ No Answer	☐ Left Message	☐ Disconnected	

Appointment Date: _____ Location: ☐ Auburndale Bartow ☐ Haines City ☐ Lakeland

Reminder Mailed on: _____ Senior Clerk: _____

PART IV – TREATMENT SUMMARY

☐ Extraction(s) ☐ Filling(s) ☐ Cleaning ☐ Debridement of calculus build-up ☐ No Show
☐ Other: _____

Medication Prescribed: _____

Follow-up in Dental Clinic: ☐ Yes ☐ No Plan: _____

Treating Dentist: _____

Date: _____

For DOH Referrals: Place patient label if available

FAX this completed form along with necessary documentation to **863-419-3497**

January 6, 2015