SPECIAL CARE CLINIC REFERRAL FORM

Date_____

Provider's Information:

Referred by _____ Clinic _____

Phone _____ Fax _____ Email _____

Address_____

_____

Patient's Information: *(Please attach Xray if applicable)*

Last Name _____ First Name _____ ID (Axium) _____

Date of Birth_____ Gender: Male Female Others

Phone Number_____ Email_____

Address_____

Primary Insurance_____

Reason for Referral: *(Please circle)*

Extremely Anxious Unable to cooperate Movement Disorder
Need Wheelchair/Lift Others_____

Additional Information

_____

_____

_____

Provider's Signature_____ **Date** _____

UTHSC COLLEGE OF DENTISTRY

SPECIAL CARE CLINIC

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