# Triax Dental referral form

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| PATIENT INFORMATION

|  |  |
| --- | --- |
| Patient’s Name: | ISP Effective Date **(N/A if no ISP)**: |
| Social Security #:  | Date of Birth:  |
| Address:  | Home Phone: |
|  Ethnicity: \*\*This information is requested because Triax Dental LLC receives federal funding and therefore must establish a system for collecting and reporting data which shows the extent to which members of protected groups are participating in federally assisted programs and activities. | Patient Weight: |
| Patient Height:  |
| Date of last dental appointment: |  |
| Assistive Devices **(wheelchair, walker, etc. N/A if no devices)**: |  |
| List all current diagnoses:  |
|  |  |
|  |
| List all medications currently being taken **(include vitamins, herbs, and over-the counter pills)**: |
|  |
|  |
| List all allergies **(including medications, foods and latex)**: |
|  |
| ISC Agency/Name **(N/A if no ISC)**:  | E-mail:  | Phone:  |
| Responsible Party for Scheduling Appointment: | E-mail:  | Phone: |
| House Manager/Staff contact **(N/A if not applicable)**: | E-mail: | Phone: |
| Conservator **(N/A if no Conservator)**: | E-mail: | Phone: |
| PCP: | Phone: | Fax: |
| Reason(s) for Referral **(Please circle all that apply)**: | Pain | Infection | Inability to Communicate pain | Restorative | Additional Information: |
| Please note if the patient will need IV sedation for:  | **Exam/Cleaning:** | Yes | No | Unknown | **Restorative:** | Yes | No |  Unknown |

Please circle Yes or no to the following questions and provide any relevant information:

|  |  |
| --- | --- |
| Have you had any serious illnesses, accidents, operations or been hospitalized in the last 5 years? Please list. | Yes No |
| Have you ever had any of the following heart diseases or complications? Circle all that apply.Congenital heart defects, Murmurs, Malfunctioning heart valves, Pacemaker, Arrhythmias or Irregular heartbeats, Ventricular or Atrial Septal defects**(If any apply, please provide documentation from a physician stating whether pre-medication is needed for any dental procedures.)** | Yes No |
| Have you ever had any of the following cardiovascular (heart) complications? Circle all that apply.Chest pain or cyanosis upon exertion, Shortness of breath on exertion, High blood pressure, Stroke, Recurrent fainting | Yes No |
| Have you been diagnosed with Sleep Apnea? | Yes No |
| Do you have any blood disorders such as Anemia or Sickle Cell Anemia? | Yes No |
| Have you or any blood relative ever had a bad or unusual reaction to anesthesia? | Yes No |
| Do you have any disease, disorder or complication not mentioned above? If yes, please explain.  | Yes No |
|  Additional Comments: |  |
|  |

I understand that withholding any information about the patient’s health could seriously jeopardize his/her safety. Therefore, I have reviewed the above medical health history carefully and have answered all questions truthfully and to the best of my knowledge.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
|  | Signature |  | Date |  |

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| **Please send a copy of a current physical, ISP (if applicable) and front/back copies of any dental insurance card (if applicable). Please also send a copy of a consent for treatment/sedation, acknowledgement of privacy practices, records release and Title VI (if applicable) signed by the patient or conservator, if there is one in place.**  |