MEDICAL-DENTAL: TEAM REFERRAL FORM

Client Name: _____ **Date of Birth:** _____

Medical Provider: Complete this section

1. Type of diabetes: ❑ Type 1 diabetes ❑ Type 2 diabetes ❑ Other Year diagnosed: _____
2. List medication(s)/insulin: _____
3. Result and date of most recent: A1C: _____ % Date: _____
4. Result and date of most recent blood pressure _____ History of cardiovascular disease: ❑ Yes ❑ No
5. Antibiotic pre-medication required? ❑ Yes ❑ No Drug allergies: _____
6. Inspection of gums and teeth: ❑ Loose, sensitive teeth, and/or separated teeth ❑ Accumulation of food debris and/or plaque around teeth
   ❑ History of abscess ❑ Red, sore, swollen, receding or bleeding gums ❑ Halitosis ❑ Missing teeth ❑ Other _____
7. Medical provider: _____
   Address: _____
   City/State: _____
   Telephone: _____ FAX: _____

Dental Provider: Complete this section

1. Date of dental visit: _____ Next dental appointment or F/U _____
2. Periodontal status (check): ❑ Gingivitis ❑ Early Periodontitis ❑ Moderate Periodontitis ❑ Advanced Periodontitis
3. Dental oral exam findings: _____
4. Treatment provided: _____
5. Dental office recommendations: ❑ F/U with healthcare provider ❑ Other _____
6. Dental provider: _____
   Address: _____
   City/State: _____
   Telephone: _____ FAX: _____

I, _____, consent to the release and exchange of medical/dental information pertinent to
Client name
my diabetes management and overall healthcare.

PLEASE FAX THIS FORM TO THE REFERRING DENTAL OR MEDICAL PROVIDER.