Please send any radiographs or photos with the referral.

Mission Children's Dental Surgery Referral
11 Vanderbilt Park Drive · Asheville, NC 28803
(828)213-1700

Please complete entire form and fax to (828)213-1705 or email to missionchildrensdental@msj.org.

Patient's Name: ________________________________ **DOB:** ________________ **Gender:** ☐ **M** ☐ **F**
(First) *(Middle)* *(Last)*

Mailing Address: ____
(Street) *(City)* *(Zip)* *(County)*

Parent's Name: ____ ☐**Mother** ☐**Father** ☐**Legal Guardian**
(First) *(MI)* *(Last)*

Home Phone: __________________ **Cell Phone:** __________________ **Work Phone:** __________________

Guardians must provide proof of guardianship before appointments can be scheduled.

Name of Other Contact: ________________ **Phone Number:** _______________ **Relationship:** ____________

Dental Insurance: ☐ **Medicaid** ☐ **Health Choice** ☐ **Other:** ______________________________ ☐ **None**

Medical Insurance: ____________________________ *****Please copy and fax front and back of insurance cards*****

Is an Interpreter Needed? ☐ **Yes** ☐ **No – If yes, language:** __________________ **Is the child in pain?** ☐ **Yes** ☐ **No**

Medical Conditions: ____

Current Medications: ____

Known Drug/Medical Allergies: ____

Exam included: ☐Explorer with Radiographs ☐Explorer Only ☐Visual Only ☐Unable to Examine

Types of Images Being Sent: ☐Radiographs ☐Intraoral Photos ☐Other: _________ ☐None

Carious Surfaces/Anticipated Treatment – Please give as much information as possible (including which teeth are okay).

1	9/F	17	25/P
2	10/G	18	26/Q
3	11/H	19	27/R
4/A	12/I	20/K	28/S
5/B	13/J	21/L	29/T
6/C	14	22/M	30
7/D	15	23/N	31
8/E	16	24/O	32

Reason this child cannot be seen as an outpatient: ☐Uncooperative Due to Age ☐Uncooperative Due to Disability ☐Uncooperative Due to Phobia ☐Amount of Treatment Required ☐Other: __________________

Printed Name of Referring Provider:______________________ **Signature:** ____________________________

NPI Number: ________________ **Mailing Address:** ____

Office Phone: ______________________ **Fax:**______________________ **Contact:** ___________________

Please DO NOT write below this point!

DDS Comments: ____________________________
____
____
____
____

☐ Screen 15 Minutes ☐ Screen 30 Minutes
☐ MOR ☐ AOR ☐McDowell ☐ Blue Ridge Regional
☐ Refused for Surgery

Surgery Length: __________ **Date:**________________

Mission Dentist's Signature: ______________________

Medical Hx Reviewed by: ____________

Date Reviewed: ____________

☐H&P with PCP Date of H&P with PCP: ___________
PCP: ____