evergreen
Hospital Dentistry

REFERRING OFFICE/PROFESSIONAL

Date Referred ______________ Referring Clinic ______________________________

City ____________________ Email ________________________ Phone # ____________________

PATIENT INFORMATION

Patient Name ____

DOB ___________ Contact name (Parent/Guardian) ____________________________

Email ___________________________________ Phone # ____________________________

Address ____

REASON FOR REFERRAL: ____

I am requesting (may choose one or more):

Dental Rehabilitation (Bilateral) under General Anesthesia in Hospital OR setting

Dental Extractions under General Anesthesia

Dental/Oral Management of Medically Complex Patients

Consult Only for Hospital Dentistry

Other: ____

Please mark teeth to be evaluated:

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

PATIENT'S CHIEF MEDICAL CONDITION(S)

Medical/Dental Diagnosis–Example: Autism Spectrum Disorder, Cleft Lip/Palate, Turner Syndrome:

____

____

ICD-10 Code(s): ____

Information check off list (PLEASE EMAIL WHERE APPLICABLE):

Dental Progress Chart Notes

Medication List, Allergies, Comorbidity

Copy of Dental and Medical Insurance Cards

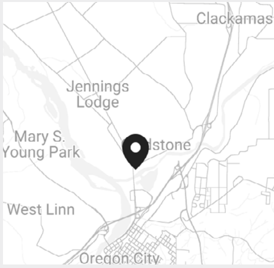
Dental Imaging:					
	X-Rays	DATE: __________	Emailed	Sent with Patient	Not on File
	CBCT	DATE: __________	Emailed	Sent with Patient	Not on File
	Intraoral Photos	DATE: __________	Emailed	Sent with Patient	Not on File

Other: ____

Preferred consult site location:
See map on the back.

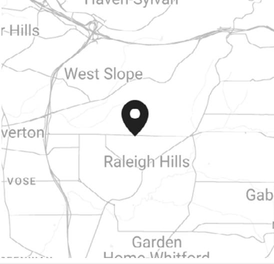
Gladstone
Portland
Albany
Salem
Hood River

CONSULTATION LOCATIONS



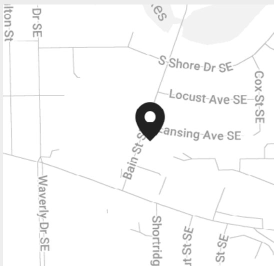
GLADSTONE OFFICE

20140 McLoughlin Blvd,
Gladstone, OR 97027



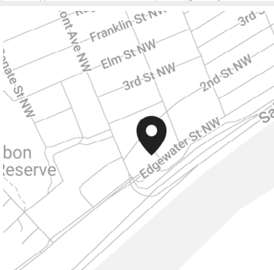
PORTLAND OFFICE

8568 SW Apple Way,
Portland, OR 97225



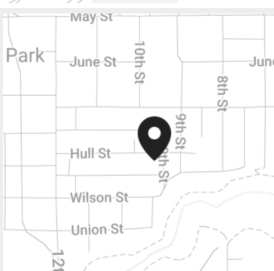
ALBANY OFFICE

1025 Bain St SE,
Albany, OR 97322



SALEM OFFICE

1353 Edgewater St NW,
Salem, OR 97304



HOOD RIVER OFFICE

1029 May Street ,
Hood River OR 97031