PEDIATRIC DENTISTRY
6400 Westwind Way
Crestwood, KY 40014
Phone: (502) 754-6633
Fax: 859-207-5102

REFERRAL FORM

Patient Name _____ DOB_____

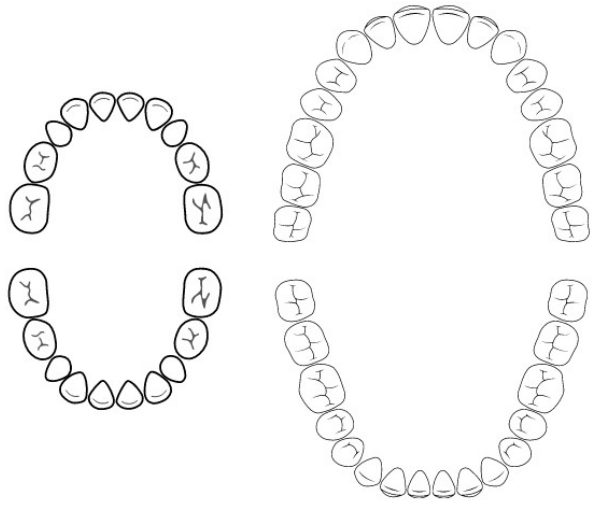
Home Adress: _____

Phone: Cell _____ Home _____

Parent's Name: _____

Reason for referral:

☐ Comprehensive Care
☐ Urgent Care
☐ Sedation
☐ Complex Medical History
☐ Extractions
☐ Pathology
☐ Tongue or Lip-tie
☐ Trauma
☐ Interceptive ortho
☐ Other (Specify Below)



Referring Doctor information

☐ X-rays Given to Parent ☐ X-rays mailed/E-mailed ☐ Needs X-rays

Will this patient be returning to your office for comprehensive care? ☐ Yes ☐ No

Referring Doctor: _____ Phone: _____

Doctor's Email address: _____

Specific Instructions: _____

Today's Date: _____

Please Fax this Form to: 859-207-5102 or
Email to info@elmpediatricdentistry.com