MAHEC

Dental Health Center

# MAHEC Dental Surgery Referral

**Please send completed form via fax: 828-552-8691**
**or Email: dentalsurgery@mahec.net**

**Date of referral: _____**

**Patient Information**

Patient's Name: _____ DOB: _____ Gender: ☐Male ☐Female

Parent/**Legal** Guardian name: _____ DOB: _____

Mailing Address: _____

Daytime Phone: _____ Cell Phone: _____ Email: _____

Insurance/Medicaid Carriers: _____ ID#: _____

Interpreter Needed? ☐Yes ☐No If yes, Language _____

Medical Conditions: _____

Current Medications: _____

Allergies: _____

What other health problems indicate care under General Anesthesia: _____

_____

**Please attach guardianship paperwork, treatment plans, clinic notes, x-rays and photos.**

**Doctor Information**

Referring Doctor: _____ Name of Practice _____

Practice Address: _____

Contact Person: _____ Contact Email: _____

Office Phone: _____ Office Fax: _____

Office use only Chart # _____

Doctors Notes: _____

_____

_____

Next step: ☐Referral Rejected ☐Schedule LOE ☐Schedule Surgery

Surgery Location: ☐Mission Main ☐Pardee

Medical Information needed: _____

Mountain Area Health Education Center
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In association with the North Carolina Area Health Education Centers Program and UNC-Chapel Hill Adams School of Dentistry