Public Health Department
Alameda County Health

Office of Dental Health

Dental Care Coordination Referral

Fax or email this form to the Office of Dental Health

Please encrypt any email that contains any personal health information including Medi-Cal number

FAX: (510) 208-5933 Email: dentalhealth@acgov.org

Questions? Please call ODH @ 510-208-5910

Date of referral (MM/DD/YY): _____ Medi-Cal ID# (if applicable): _____

1.Patient: Last name: _____First name: _____Gender: M ☐ F ☐ Other ☐

Date of birth (MM/DD/YY): _____Phone #: _____

Address: _____Apt#: _____City: _____Zip code: _____

Ethnicity: _____ Decline to state: ☐

2.Parent or guardian: Last name: _____ First name: _____

Email: _____ Phone #: _____

3.Language spoken: _____ Translation needed ☐

4.Transportation support needed: No ☐ Yes ☐

5.Special Health Care Needs: No ☐ Yes ☐ (If yes, please elaborate below.)

_____

_____

6.Perinatal/Postpartum x 12 months: No ☐ Yes ☐

7.Referred by: Contact person: _____ Name of organization: _____

E-Mail: _____City: _____Phone #: _____Fax #: _____

8.Reason for referral: ☐Routine dental care

☐ Urgent (tooth pain, broken tooth, swelling)

Please explain: _____

_____

_____

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