Alameda County Public Health Dental Program Referral

FAX/EMAIL THIS FORM TO THE OFFICE OF DENTAL HEALTH

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):**__________________ ☐Special Needs

1. Patient: Last Name:____________________First Name: ___________________ Gender: ☐M ☐F ☐Other

Date of Birth (MM/DD/YY):_________Phone #:_________________Language: ___________________

Address:____Apt#_____City:____________Zip Code: ___________

2. Parent/Guardian: Last Name:_____________________________First Name: _____________________

Email: ____

3. Language: ____ ☐ Translation Needed

4. Referred from:

Name of CHDP/School/Clinic/Organization:_____________________Contact Person: ____________________

E-Mail:___________________City:________________Phone #:________________Fax #: ____________________

5. Dental Referral is:

☐ For Routine Dental Care/Dental Home Referral

☐ **Urgent**

Please explain:____

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FOR ALAMEDA COUNTY OFFICE OF DENTAL HEALTH USE ONLY

Referral outcome	

Other Comments:

HS ID#______________HKHT ID# __________________

AA Revised May 12, 2021