Public Health Department
Alameda County 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: _____

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: _____

   _____

   _____

   _____