Referral Form
UNC Hospitals Dental Clinic
101 Manning Drive, Chapel Hill, NC 27514
Phone (984) 974-1485, Option 2
Fax (984) 974-0355

REFERRALS ARE ACCEPTED VIA EPIC, UNC CARELINK, OR BY FAX. REFERRALS ARE NO LONGER ACCEPTED VIA EMAIL.
OUTSIDE PROVIDERS: ALL INFORMATION ON THIS FORM MUST BE COMPLETED AND FAXED TO 984-974-0355.
INCOMPLETE REFERRAL FORMS WILL NOT BE PROCESSED.

Thank you for your interest in referring your patient to the UNC Hospitals Dental Clinic. Our Dental Clinic's mission is to use our clinical expertise to provide excellent dental care to medically compromised patients, inpatients and hospital staff members. If you have any questions about our clinic's referral policy, please contact our office.

PATIENT DEMOGRAPHIC INFORMATION

First Name _____ Middle Initial _____ Last Name _____

Date of Birth _____ /_____ /_____ Street Address _____

City _____ State _____ Zip Code _____

Phone # _____ Alternate Phone # _____

REASON FOR THE REFERRAL

If the patient does not meet any of the following criteria, please refer to other dental facilities for their dental needs.

Please indicate the patient's qualifying medical condition:

- ❑ Hematologic /Coagulation Disorders
- ❑ Head and Neck Cancer/Radiation Therapy Patients
- ❑ IV Bisphosphonate (Evaluate Prior to (and/or) following treatment)
- ❑ Transplantation (Stem Cell Transplant or Organ Transplant)
- ❑ Cardiothoracic Surgery Patient (Endocarditis, Cardiac valve replacement surgery)
- ❑ Orthopedic Patient (Pre-Total joint replacement therapy to reduce risk of surgical site infection)
- ❑ Intellectual/Developmental Disabilities (Autism, Dementia, Down Syndrome)
- ❑ Immunodeficiency/Autoimmune Disorders (Risk for dental care without medical/dental collaboration)
- ❑ Respiratory Conditions (Cystic Fibrosis, airway compromise, and ventilator or severe oxygen dependency for medical necessary dental care)
- ❑ Trauma Patients (Traumatic injury to teeth and structures of the oral cavity)

Please Specify Above Condition (Required) _____

Allergies _____

Radiographs ❑ Please take ❑ Previous x-rays available and will be emailed directly to the patient.

REFERRING PROVIDER INFORMATION

Referring Doctor Name _____ Phone # _____

Fax # _____ Additional Office Contact Name _____

DENTAL INSURANCE INFORMATION

Name of Dental Insurance Company: _____ Insurance Co. Phone # _____

Patient is policy holder? ❑ Yes ❑ No If no, Policy Holder Name _____ DOB _____

Policy ID # _____