SEK SMILES REFERRAL FORM

2100 Commerce Dr, Parsons, KS 67357
1-888-204-0505
Fax 620-717-4540

Patient name: _____ Patient DOB: _____

Parent/Guardian Name: _____

Address: _____

Phone Number:_____

Referring Dentist: _____

Requested consultation/treatment

- ☐ Consultation only (Assess and Recommend)
- ☐ Consultation and comprehensive treatment (Assess and Treat)
- ☐ Consultation and limited treatment, specify_____
- ☐ Establish dental home *(for outside dental practices)*
- ☐ Specialty treatment is medically necessary

Reason for Referral

- ☐ Rampant caries
- ☐ Early Childhood Caries (ECC)
- ☐ Special Needs
- ☐ Anxiety/behavior
- ☐ Oral surgery (under the age of 12)
- ☐ Medical concerns, specify_____
- ☐ Dental concerns, specify_____

Child Behavior (Frankl rating)

- ☐ 1 – Total lack of cooperation.
- ☐ 2 – Signs of lack of cooperation.
- ☐ 3 – Accepts treatment with caution.
- ☐ 4 – No signs of resistance. Very cooperative.

Attempted treatment:

Please send this r**eferral form, current xrays and copy of insurance, if applicable, to***:*

seksmiles@chcsek.org