Boston Children's Hospital
Department of Dentistry
300 Longwood Avenue | Mail stop: HU - 226
Boston, Massachusetts 02115
phone 617-355-6571 | *fax* 617-730-0478
www.childrenshospital.org/dentistry

Patient Referral Form

Please be advised, consults generally book 3-5 months out. Urgent referrals will be evaluated on a case by case basis. For urgent referrals please call (617) 355-6571

Please note BCH is in network with, MassHealth, Dental Blue and Delta Dental of MA, with the exception of EPO and MPE Plans for routine dental care and United Health Care, Fallon, NHP and NH Wellsense for treatment under general anesthesia. Each case will be reviewed individually.

Patient Name:

Date of Birth:

Parent/Guardian Name:

Relationship:

Address (Street, City, State Zip):

Parent/Guardian Phone Number:

E-mail address:

Interpreter needed?
◯ No
◯ Yes - Language spoken:

Has patient ever been seen at BCH? ◯ Yes ◯ No

Dental Insurance:

Subscriber Name:

Subscriber DOB:

Subscriber ID:

Group Number:

Medical Insurance:

Subscriber Name:

Subscriber DOB:

Subscriber ID:

Group Number:

SECTION BELOW TO BE FILLED BY REFERRING DENTAL OFFICE

Referring Office:

Referring Dentist:

Address (Street, City, State Zip):

Office Phone Number:

E-mail address:

Reason patient is being referred to BCH?

- ☐ Restorative Care
- ☐ Extractions only
- ☐ Sedation/GA
- ☐ Behavioral Condition
- ☐ Medically Complex
- ☐ Transfer of Care
- ☐ Other

****If patient is medically complex, please attach last clinical note to this form****

Date of last cleaning:

Date of most recent x-rays:

****If applicable please attach digital images to this form****

Does the patient need antibiotic prophylaxis?

- ◯ Yes
- ◯ No

Has the patient had 2 or more failed attempts of treatment with procedural sedation or nitrous oxide?

- ◯ Yes
- ◯ Not Applicable
- ◯ No

If **YES**, please provide the dates

First attempt:

Second attempt:

Please e-mail this completed form, along with a referral letter and *ALL* supporting documents to DentalReferrals@childrens.harvard.edu with patient's name and DOB in the subject line.