



DENTAL REFERRAL FORM

Please choose the closest location and FAX to: Community Smiles Dental

For our **Waukesha** location fax to: 1-262-522-2828

For our **Menomonee Falls** location fax to: 1-262-502-0508

Once received by CSD and if there is an urgent need, patient should expect a call from CSD within 24 hours

Referring agency (please print) _____ Date _____

Agency information (referring provider name, address, and phone number):
office stamp acceptable

Patient Name: _____ DOB: _____

Phone: _____ Preferred Language: _____

Does the patient have Medicaid insurance? Please circle: Yes No

If yes, Forwardhealth ID #: _____

The patient was screened and is being referred to CSD for:

Please check ANY that apply:

- Swelling
- Pain
- Other urgent need: _____
- Visible cavities Description of cavities: _____
- Routine Exam/Cleaning

Please provide any context regarding your clinical exam and reason for referral. Are there any special needs or behavioral challenges?

Waukesha Clinic address: 210 NW Barstow Street, Suite 305 Waukesha, WI 53188

Menomonee Falls Clinic address: N81W15062 Appleton Avenue Menomonee Falls, WI 53051