UTHealth Houston | School of Dentistry

Fondren Foundation Special Patient Clinic
Dental Referral Form

IMPORTANT:

This medical history form is to refer a patient with complex medical conditions and/or physical needs, for a screening and assessment for consideration of acceptance, into the Fondren Foundation Special Patient Clinic at the School of Dentistry. This form **DOES NOT** guarantee that the referred patient will be accepted as a patient to any of our teaching clinics.

If the patient has an **appointed legal guardian** or **medical power of attorney**, the following are both **REQUIRED** for the initial assessment visit:

1. **A copy of legal guardianship or medical power of attorney documents for our records.**

2. **The legal guardian/representative must accompany the patient to their initial assessment visit to discuss the patient's medical history, special care needs, dental findings, treatment recommendations and consent to the accepted treatment plan.**

If these requirements are not met, it will result in the delay of scheduling the initial assessment or the appointment will be rescheduled to a future date.

INSTRUCTIONS:

Please complete all the pages of the Medical Data Form (MDF) by filling out the following sections:

1. **Patient & Emergency Contact Information**

2. **Patient Medical Conditions / Medications / Additional Information**

3. **Referring Physician Information**

*****If any of the requested information on the form is missing or incomplete, the referral form will not be processed and will be returned to the referring provider. Referrals may be submitted using one of the following options:**

- **Electronically through our UTHealth Houston SecureStor portal: Kiteworks**
  1. Email to **ONLY** request for the instructions at: dentalrecords@uth.tmc.edu
  2. Response to your email will include instructions
  3. Wait for a separate email to be sent with a link to our secure portal
  4. Use the instructions on how to create an account to send the MDF through our secure portal

- **Fax directly to 713-486-4322**

- **Mail to address:**

  UTHealth Houston School of Dentistry
  ATTN: HIM
  RE: MDF
  7500 Cambridge St., Suite 1310
  Houston, TX 77054

Thank you for choosing the School of Dentistry and referring your patient. If you have any questions, please contact our clinic at 713-486-4296.

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Medical Data Form

Attending Physician/Primary Care Provider

**** Please answer the questions below and print legibly. This is a medical screening questionnaire and requires a complete update by the patient's attending physician or primary care provider prior to the patient receiving comprehensive dental care. ****

Patient Information

Last Name: _____ **First Name:** _____ **Middle:** _____

Date of Birth: _____ **Sex:** ☐ Male ☐ Female ☐ Transgender

Primary Phone#: _____ ☐ Home ☐ Work ☐ Mobile ☐ Other: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Emergency Contact Information

Last Name: _____ **First Name:** _____ **Middle:** _____

Phone#: _____ **Other#:** _____

Relation: *(Select one)* ☐ Child ☐ Guardian ☐ Parent ☐ Sibling ☐ Spouse ☐ Other

Medical Conditions

Please indicate if the patient has (or have had) any of the following diseases, problems, or symptoms and provide details, as applicable, such as severity and how well the conditions are controlled.

Cardiovascular System: ☐ None

☐ Atrial Fibrillation ☐ CHF ☐ Heart Murmur ☐ Mitral Valve Prolapse ☐ Stroke

☐ CAD ☐ DVT ☐ HTN ☐ Pacemaker

☐ Cardiac Arrhythmia ☐ Heart Attack ☐ Infective Endocarditis ☐ Cardiac Arrhythmia

☐ Other: _____

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Renal/GI Systems: ☐ None

☐ Cirrhosis/Liver Disease ☐ Crohn's Disease ☐ Hepatitis/Jaundice

☐ Colitis ☐ GERD ☐ Renal Disease:

☐ Hemodialysis or ☐ Peritoneal Dialysis

☐ Other: _____

Respiratory System: ☐ None

☐ Asthma ☐ COPD/Bronchitis ☐ Pneumonia ☐ Tuberculosis

☐ Other: _____

Muscular/Skeletal System: ☐ None

☐ Arthritis ☐ Gout ☐ Motor Disabilities ☐ Osteoporosis

☐ Other: _____

_____

Endocrine System: ☐ None

☐ Diabetes: A1C _____ ☐ Thyroid Disorder ☐ Other: _____

Immunologic System: ☐ None

☐ Autoimmune Disorder ☐ Organ Transplant ☐ Other: _____

Neurologic/Psychiatric System: ☐ None

☐ Alzheimer's Disease ☐ Autism ☐ Cerebrospinal Shunt ☐ Communication Disorders ☐ Depression

☐ Anxiety Disorder ☐ Cerebral Palsy ☐ CNS Disorder ☐ Dementia ☐ Parkinson's Disease

☐ Seizure/Epilepsy (Type and last occurrence): _____

☐ Other: _____

_____

Oncologic System: ☐ None

☐ Cancer or Neoplasia (Type and location): _____

☐ Chemotherapy ☐ Radiation (Amount): _____ ☐ Steroid Therapy

☐ Other: _____

_____

Hematologic System: ☐ None

☐ Bleeding Disorder

☐ Hemophilia A ☐ Idiopathic Thromobcytopenia Purpura (ITP) ☐ Von Willebrand Disease

☐ Hemophilia B ☐ Medication Induced

☐ Other: _____

_____

Other:

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Medications			
List all current medications and herbal supplements. ****Attach for more****			
Drug Name:	**Dose: (mg)**	**Frequency:**	**For what condition?**

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Additional Information

1. Any drug allergies? ☐ No ☐ Yes
   If yes, please explain: _____

_____

_____

2. Patient's Mobility Status: ☐ Ambulant ☐ Stretcher/Bed Patient ☐ Wheelchair

3. What is your medical evaluation with regard to the patient's ability to undergo oral health care that may include dental cleaning, restorations, root canals, and/or oral surgery under local anesthesia? (may include use of nitrous oxide)

_____

_____

_____

4. Do you anticipate the patient needing oral sedation/IV sedation for dental treatment? ☐ No ☐ Yes

5. Do you recommend antibiotic pre-medication prior to dental treatment? ☐ No ☐ Yes
   If yes, please explain the condition, reason, type, and dosage: _____

_____

_____

6. Does the patient have a legal guardian or medical power of attorney? ☐ No ☐ Yes
   If yes, please provide legal guardian/representative's name and attach any supporting documentation on file:

_____

Referring Physician

Provider's Name: _____

Specialty: _____

Entity: _____

Phone: _____ **Fax:** _____

Email: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Provider's Signature: _____ **Date:**_____