Children's Hospital
New Orleans
LCMC Health

Pediatric Dentistry Referral Form

Phone: 504.896.2888
Fax: 504.896.2889
CHNOreferrals@LCMChealth.org

Date of Referral: _____

Patient Information:

Patient Name: _____
Parent/Guardian Name: _____
Patient Date of Birth: _____ Phone: _____
Medical Insurance: _____ Dental Insurance: _____
Member ID: _____ Member ID: _____
Medical History:

_____
_____
Medications: _____
Allergies: _____

Reason/Concern for Referral:

☐ Fillings - Teeth #'s: _____
☐ Crowns - Teeth #'s: _____
☐ Extractions - Teeth #'s: _____
☐ Pulp Therapy - Teeth #'s: _____
☐ Behavior Management - In office: _____ General Anesthesia: _____

Were radiographs obtained? ☐ Yes ☐ NO

If yes, please send radiographs to CHNOreferrals@LCMChealth.org
Comments:

_____
_____

Referred By:

Provider: _____
Address: _____
Phone: _____

CHNOLA Dental Office

Phone – 504.896.1337
Fax – 504.896.9581