KERN COUNTY
Public Health Services
DEPARTMENT

DENTAL REFERRAL

Please fill out entire referral except the boxed section and fax to CHDP Attn: Imelda Ceja-Butkiewicz or Jennifer Ansolabehere at 661-868-0493. For questions call Imelda at 868-1201 or email: imeldacb@co.kern.ca.us

*Child's Name _____ *DOB _____ Referral Date _____

*Parent/Guardian Name _____ *Phone _____ Child's Age _____

Address _____ City _____ Zip Code _____

Reason for Referral: Routine ☐ Age 1 ☐

Suspected Problem: _____

Any Medical Precautions for Treatment: Yes ☐ No ☐

Explain: _____

ALERT: Taking medications ☐ Has allergies ☐ Has asthma ☐

Does child currently have a dental home? Yes ☐ No ☐

Referring Clinic/PCP: _____ Date: _____

********Information Below for CHDP Use Only********

Dental Tracking Form

Insight #: _____

Assigned to: _____ Date: _____

☐ Services Initiated ☐ Unable to Contact ☐ Declined Services

Services Provided: Oral health education/instructions ☐ Fluoride varnish/Topical fluoride ☐

Dental kit provided ☐

Comments: _____

Contact follow-up completed by: Date: