ALAMEDA COUNTY HEALTH CARE SERVICES AGENCY
PUBLIC HEALTH DEPARTMENT
OFFICE OF DENTAL HEALTH

Dental Care Coordination Referral

Fax or email this form to the Office of Dental Health

Please encrypt any email that contains any personal health information including Medi-Cal number

FAX: (510) 208-5933 Email: dentalhealth@acgov.org

Questions? Please call ODH @ 510-208-5910

Date of referral (MM/DD/YY):__________________ Medi-Cal ID# (if applicable): _________________

1. **Patient:** Last name: __________________First name: __________________Gender: ☐ M ☐ F ☐ Other

   Date of birth (MM/DD/YY): ______________________Phone #:________________________________

   Address: _________________________________Apt#: _____City:____________Zip code: ____________

2. **Parent or guardian:** Last name: _______________________ First name: ____________________

   Email: ______________________________________ Phone #:____________________________

3. **Language spoken:** _____________________________ ☐ Translation needed

4. **Referred by:** Contact person: ______________________ Name of organization: ________________________

   E-Mail: ________________________City: ____________Phone #: ______________Fax #: ________________

5. **Reason for referral:** ☐ Routine dental care

   ☐ Urgent (tooth pain, broken tooth, swelling)

   Please explain:____

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FOR OFFICE OF DENTAL HEALTH USE ONLY

Referral outcome	
Other Comments:	

HS ID#__________________HKHT ID#____________________

JY Revised June 23, 2022