

Online Referral Reference Guide

The following instructions detail how to submit referrals to The Dental Specialists using the electronic referral web page. If you have any questions or need assistance, please contact the specialty office you are referring the patient to.

The Dental Specialists **The Dental Specialists High Pointe**
8650 Hudson Blvd., Ste. 105
Lake Elmo, MN 55042-3416
651-633-0900

QSI Dental

Patient Referral

1 **Referred By**

Last, First Name* Referral Doctor
Practice Name (Optional)
Office Address* 5500 North Main St
City, State Zip* Roseville MN 55113
Email* youremail@email.com

2 **Referred To**

Office* The Dental Specialists High Poi
Specialty* Endodontics
Provider Name* Law, Alan(DR1254)

3 **Referred Reason**

Procedure Requested* Consultation
Tooth Number/Or Tooth Area* 3,4,5
Referral Note
4 Type in any comments that should be shared with the Referring Doctor. (i.e. Patient will call you to schedule)

5 **Patient Personal Information**

Title Nickname
Last, First* Jones Tom
Address* 2215 13th Street West
City, State Zip* Maple Grove MN 55311
Email* tomjones@email.com
Birth Date* 09/28/1970
Age 34
Marital Status Single
Sex Male
Home #* 763-555-1212
Work # 763-500-9000
Cell # 612-899-0000
Drive Lic
Student No
School Name

6 **Attachment**

Attach File

7 **Medical Alerts**

Do You Have the Following:

- Amoxicillin Allergy
- Aspirin or Ibuprofen Allergy
- Anesthetic Allergy
- Cancer/Tumor Growth
- Chemotherapy/Radiation
- Communication Issue
- Dental/Oral Delay
- Chronic Cough
- COPD
- Emphysema
- Pneumonia

Check, if Applicable

- Premedication Needed
- Alcohol/Drug Abuse
- Lung Problems
- Asthma
- Bronchitis
- Artificial Joints
- Back Problems
- History of Skin Problems
- Joint Problems
- Muscle Problems
- Neck Problems
- Osteoporosis

8 **NERVOUS SYSTEM PROBLEMS**

- ADD/ADHD
- Alzheimer's Disease
- Anorexia/Bulimia
- Liver Disease
- Measles, Mumps, Chickenpox

Cancel Registration Submit Referral

Please refer to the detailed examples below for further assistance. The numbers above correlate to each section below.

1 **Referred By**

Last, First Name* Referral Doctor
Practice Name (Optional)
Office Address* 5500 North Main St
City, State Zip* Roseville MN 55113
Email* youremail@email.com

Fields with * are required.

Enter a Zip Code and select the City to auto-populate the fields. Click the 'x' to close the window.

2 **Referred To**

Office* 1 The Dental Specialists High Poi
Specialty* 2 Endodontics
Provider Name* 3 Law, Alan(DR1254)

Using the Drop Downs, select the Office, Specialty and Provider in the order illustrated.

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Procedure Requested* Consultation

Tooth Number/Or Tooth Area* 3,4,5

Tooth Numbers															
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
A	B	C	D	E	F	G	H	I	J						
T	S	R	Q	P	O	N	M	L	K						
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

Tooth Area

UL	LL	UR	LR	UA	LA	FM
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Close Use

Select the Procedure Requested and Tooth Number.

4

Referral Note

Type in any comments that should be shared with the Referring Doctor. (i.e. Patient will call you to schedule)

Enter any pertinent patient information that should be shared.

5

Patient Personal Information

Title [v] Nickname [v]

Last, First* Jones, Tom

Address* 2215 13th Street West

City, State Zip* Maple Grove MN 55311

Email* tomjones@email.com

Birth Date* 09/28/1970 Age [v]

Marital Status Single Sex Male

Home #* 763-555-1212 Work # 763-500-9000

Cell # 612-899-0000 Drive Lic [v]

Student No

School Name [v]

Continue entering Patient Personal Information.

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Attachment

To send images or documents with the referral, select the Attach File icon

Attached files show as an icon on the left side of the screen

Select Browse to find the file(s) and OK to attach to the referral

Attach File

Upload Referral Document

Please Select File *

(Allowed extensions are: .gif, .jpg, .png, .pdf, .doc & .docx. File size limit is 4MB)

Browse

OK Cancel

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Medical Alerts

Do You Have the Following:

<input checked="" type="checkbox"/> Amoxicillin Allergy	<input type="checkbox"/> Cancer/Tumor Growth	<input type="checkbox"/> NERVOUS SYSTEM PROBLEMS
<input type="checkbox"/> Aspirin or Ibuprofen Allergy	<input type="checkbox"/> Chemotherapy/Radiation	<input type="checkbox"/> ADD/ADHD
<input type="checkbox"/> Augmentin Allergy	<input type="checkbox"/> Communication Issue	<input type="checkbox"/> Alzheimer's Disease
<input type="checkbox"/> Epinephrine Sensitivity	<input type="checkbox"/> Developmental Delay	<input type="checkbox"/> Anorexia/Bulimia
	<input type="checkbox"/> Learning Problems	<input checked="" type="checkbox"/> Anxiety
	<input type="checkbox"/> Rheumatoid Arthritis/Sjogren	<input type="checkbox"/> Migraine Head
<input type="checkbox"/> Sedatives/Barbiturates Allergy	<input type="checkbox"/> Glaucoma	<input checked="" type="checkbox"/> Migraines
<input type="checkbox"/> Sulfa Drugs Allergy	<input type="checkbox"/> Large Tonsils or Adenoids	<input type="checkbox"/> Cerebral Dystrophy
<input type="checkbox"/> Other Allergy (list on Medical History)	<input checked="" type="checkbox"/> Hay Fever/Seasonal Allergies	<input type="checkbox"/> Hearing Areas
Are You Taking the Following:	<input type="checkbox"/> Mastoid Infection	<input type="checkbox"/> Vision

(Optional Section) Select any Medical Alerts that should be shared

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Once the On-Line referral is complete, click on Submit Referral

Cancel Registration Submit Referral