The Dental SPECIALISTS

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 assitance, please contact the specialty office you are referring the patient to.

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

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.

Please select: MN - Falcon Heights, MN - Falcon Hgts, MN - Lauderdale, MN - Roseville

Referred To

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

Use the Drop Downs to select the appropriate information

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Referred Reason

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

Close Use

3 Select the Procedure Requested and Tooth Number.

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

4 Enter any pertinent patient information that should be shared.

Title / Nickname

Last, First* — Jones, Tom

Address* — 2215 13th Street West

City, State Zip* — Maple Grove, MN 55311

Email — (Optional)

Birth Date* 09/28/1970 — Age 44

Marital Status Single — Sex Male

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

Cell # 612-899-0000 — Drive Lic

Student No

School Name

5 Continue entering Patient Personal Information.

Attachment — Attach File

6 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

Upload Referral Document — Please Select File * (Allowed extensions are: .gif, .jpg, .png, .pdf .doc & docx. File size limit is 4MB) Browse... OK Cancel

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

Medical Alerts

Do You Have the Following:

- Amoxicillin Allergy (checked)
- Aspirin or Ibuprofen Allergy
- Augmentin Allergy
- Epinephrine Sensitivity
- Penicillin Allergy
- Sedatives/Barbiturates Allergy
- Sulfa Drugs Allergy
- Other Allergy (list on Medical
- Cancer/Tumor Growth
- Chemotherapy/Radiation
- Communication Issue
- Developmental Delay
- Learning Problems
- Frequent Dry Mouth/Sjogren
- Glaucoma
- Large Tonsils or Adenoids
- Hay Fever/Seasonal Allergies (checked)
- Hearing Impaired
- Pneumonia
- Reactive Airway Disease
- Low Blood Pressure
- Leg Bypass Surgery

GASTROINTESTINAL PROB

- Acid Reflux
- Cirrhosis

NERVOUS SYSTEM PROBLEMS

- ADD/ADHD
- Alzheimer's Disease
- Anorexia/Bulimia
- Anxiety (checked)
- Injury to Head
- Migraines (checked)
- Muscular Dystrophy

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

Cancel Registration — Submit Referral

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