


Online Referral Reference Guide

The following instructions detail how to submit referrals to The Dental Specialists using the new electronic referral web page. If you have any questions or need assistance, please contact the specialty office you would like the patient to be seen at.



The Dental Specialists Radio Drive
241 Radio Dr Ste A
Woodbury, MN 55125-2040
651-760-3661

Patient Referral

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

Referred To

Office* The Dental Specialists High Poi

Specialty* Endodontics

Provider Name* Law, Alan(DR1254)

Referred Reason

Procedure Requested* Consultation

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

Referral Note

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

Patient Personal Information

Title Mr Nickname Tom

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 44

Marital Status Single Sex Male

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

Cell # 612-899-0000 Drive Lic

Student No School Name

Attachment

Attach File

Medical Alerts

Do You Have the Following:

☒ Amoxicillin Allergy

☐ Aspirin or Ibuprofen Allergy

☐ Sulfonamide Allergy

☐ Prola

☐ Reclast

☐ Zometa

☐ Other Bisphosphonates

Check, if Applicable

☐ Premedication Needed

☐ Alcohol/Drug Abuse

☐ Cancer/Tumor Growth

☐ Chemotherapy/Radiation

☐ Communication Issue

☐ Dental/Oral Delay

☐ Irregular Heart Beat

☐ Pacemaker

☐ Defibrillator

☐ Rheumatic Fever

LUNG PROBLEMS

☐ Asthma

☐ Bronchitis

☐ Chronic Cough

☐ COPD

☐ Emphysema

☐ Pneumonia

☐ Artificial Joints

☐ Back Problems

☐ History of Skin Problems

☐ Joint Problems

☐ Muscle Problems

☐ Neck Problems

☐ Osteoporosis

NERVOUS SYSTEM PROBLEMS

☐ ADD/ADHD

☐ Alzheimer's Disease

☐ Anxiety/Phobias

☐ Liver Disease

☐ Measles, Mumps, Chickenpox

Cancel Registration
Submit Referral

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

Referred To

Office* The Dental Specialists High Poi

Specialty* Endodontics

Provider Name* Law, Alan(DR1254)

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	K	L	M	N	O	P
Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF

Tooth Area

UL	LL	UR	LR	UA	LA	FM
----	----	----	----	----	----	----

Close Use

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

Referred To

Office* The Dental Specialists High Poi

Specialty* Endodontics

Provider Name* Law, Alan(DR1254)

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	K	L	M	N	O	P
Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF

Tooth Area

UL	LL	UR	LR	UA	LA	FM
----	----	----	----	----	----	----

Close Use

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

Referred To

Office* The Dental Specialists High Poi

Specialty* Endodontics

Provider Name* Law, Alan(DR1254)

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	K	L	M	N	O	P
Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF

Tooth Area

UL	LL	UR	LR	UA	LA	FM
----	----	----	----	----	----	----

Close Use

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

Referred To

Office* The Dental Specialists High Poi

Specialty* Endodontics

Provider Name* Law, Alan(DR1254)

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	K	L	M	N	O	P
Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF

Tooth Area

UL	LL	UR	LR	UA	LA	FM
----	----	----	----	----	----	----

Close Use

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

Referred To

Office* The Dental Specialists High Poi

Specialty* Endodontics

Provider Name* Law, Alan(DR1254)

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	K	L	M	N	O	P
Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF

Tooth Area

UL	LL	UR	LR	UA	LA	FM
----	----	----	----	----	----	----

Close Use

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

Referred To

Office* The Dental Specialists High Poi

Specialty* Endodontics

Provider Name* Law, Alan(DR1254)

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	K	L	M	N	O	P
Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF

Tooth Area

UL	LL	UR	LR	UA	LA	FM
----	----	----	----	----	----	----

Close Use

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

Referred To

Office* The Dental Specialists High Poi

Specialty* Endodontics

Provider Name* Law, Alan(DR1254)

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	K	L	M	N	O	P
Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF

Tooth Area

UL	LL	UR	LR	UA	LA	FM
----	----	----	----	----	----	----

Close Use

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

Referred To

Office* The Dental Specialists High Poi

Specialty* Endodontics

Provider Name* Law, Alan(DR1254)

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	K	L	M	N	O	P
Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF

Tooth Area

UL	LL	UR	LR	UA	LA	FM
----	----	----	----	----	----	----

Close Use

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

Referred To

Office* The Dental Specialists High Poi

Specialty* Endodontics

Provider Name* Law, Alan(DR1254)

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	K	L	M	N	O	P
Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF

Tooth Area

UL	LL	UR	LR	UA	LA	FM
----	----	----	----	----	----	----

Close Use

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

Referred To

Office* The Dental Specialists High Poi

Specialty* Endodontics

Provider Name* Law, Alan(DR1254)

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	K	L	M	N	O	P
Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF

Tooth Area

UL	LL	UR	LR	UA	LA	FM
----	----	----	----	----	----	----

Close Use

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

Referred To

Office* The Dental Specialists High Poi

Specialty* Endodontics

Provider Name* Law, Alan(DR1254)

Referred Reason

Referral Note **4** 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			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	44
Marital Status	Single	Sex	Male
Home # *	763-555-1212	Work #	763-500-9000
Cell #	612-899-0000	Drive Lic	
Student	No		
School Name			

Continue entering Patient Personal Information.

6 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

7 Medical Alerts

Do You Have the Following:

<input checked="" type="checkbox"/> Amoxicillin Allergy	<input type="checkbox"/> Cancer/Tumor Growth	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> ADD/ADHD
<input type="checkbox"/> Aspirin or Ibuprofen Allergy	<input type="checkbox"/> Chemotherapy/Radiation	<input type="checkbox"/> Reactive Airway Disease	<input type="checkbox"/> Alzheimer's Disease
<input type="checkbox"/> Augmentin Allergy	<input type="checkbox"/> Communication Issue	<input type="checkbox"/> Leg Bypass Surgery	<input type="checkbox"/> Anorexia/Bulimia
<input type="checkbox"/> Epinephrine Sensitivity	<input type="checkbox"/> Developmental Delay	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Penicillin Allergy	<input type="checkbox"/> Learning Problems	<input type="checkbox"/> Frequent Urinary Infection/Syphilis	<input type="checkbox"/> Migraines
<input type="checkbox"/> Sedatives/Barbiturates Allergy	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Large Tonsils or Adenoids	<input type="checkbox"/> Myocardial Dystrophy
<input type="checkbox"/> Sulfa Drugs Allergy	<input type="checkbox"/> Hay Fever/Seasonal Allergies	<input type="checkbox"/> Acid Reflux	<input type="checkbox"/> Asthma
<input type="checkbox"/> Other Allergy (list on Medical)	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Carbonate	<input type="checkbox"/> Diabetes

Are You Experiencing the Following:

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

Cancel Registration Submit Referral

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