



LifeCycle Dental Referral/Information Form

Date: _____

Facility Name: _____

Person Making Referral: _____

Resident's Name: _____

Resident's Room # _____



Bookkeepers Information: REQUIRED

Applied Income: \$ _____

Is the Residents Rent Current? _____

If a refund is generated who is it mailed to?

Nursing Home _____ **or Family** _____

Private Pay: _____ **Yes** _____ **No**

Social Worker Information

Dental Problem or Complaint:

a. Has Natural Teeth: YES NO

b. Has Dentures/Partials YES NO

c. Is Patient in Pain YES NO

Specific Dental Problem: _____

Please include the following with this referral

CURRENT FACE SHEET

CURRENT MEDS LIST

FAX TO: 817-439-8774