SEATTLE
SPECIAL CARE DENTISTRY™

Amy Winston, DDS
Lauren Vainio, DDS
Noah Letwin, DDS, PhD
Salma Helal, DDS

Patient Name: _____

Guardian/Contact (If applicable): _____

Referral Date: _____ **Date of Birth:** _____

Phone (primary): _____ **Phone (alternate):** _____

Insurance: _____ ☐ **None**

Referring Provider: _____

Contact phone/Email: _____

Urgency: ☐ **< 48 hrs *(please call SSCD)*** ☐ **< 2 wks** ☐ **Routine**

Reason for referral:

- ☐ **Medically complex**
- ☐ **Developmentally Disabled/Special needs**
- ☐ **Transplant**
- ☐ **Radiation Oncology**
- ☐ **Medical Oncology**
- ☐ **Hemophilia**
- ☐ **IV sedation/GA**
- ☐ **Other**

Additional History and Information: _____

Map / directions on reverse

Thank you for your referral!

206-524-1600 (ph)
206-524-1603 (Fax)
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