BRANCH-HILLSDALE-ST. JOSEPH COMMUNITY HEALTH AGENCY | YOUR LOCAL HEALTH DEPARTMENT
www.bhsj.org

Branch-Hillsdale-St. Joseph Community Health Agency
Kindergarten Oral Health Assessment Referral Form

Your child has been identified as needing urgent evaluation by a dentist of your choice. The need for urgent care means that your child has a tooth or teeth that appear to need immediate care as there is pain, infection, or swelling. A list of providers who accept Medicaid insurance can be found at www.bhsj.org/resources/2527, or by using the QR code you were provided.

Please print this form. Request the treating dentist to complete and fax it to 517-278-2923. If have additional questions, you can contact me by phone at 517-462-9728 or by email at koha@bhsj.org.

If you need assistance to apply for Medicaid, or the Healthy Kids Dental Program, call your local health department office and press option 5.

To the Provider: Please complete the below information.

Patient's Name_____**DOB**_____

Patient's School:_____

Appointment Date(s): _____**Treatment Complete Y / N**

Provider Name and Location: _____

_____

Please email the form to koha@bhsj.org or fax to 517-278-2823. Thank you!

Angela Shedd. BS, RDH

570 N. Marshall Road
Coldwater, MI 49036
(517) 279-9561
(517) 278-2823 Fax

20 Care Drive
Hillsdale, MI 49242
(517) 437-7395
(517) 437-0166 Fax

1110 Hill Street
Three Rivers, MI 49093
(269) 273-2161
(269) 273-2452 Fax

1555 E. Chicago Rd
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