Dental Referral Form

CareOregon Dental

Priority: ☐ Routine ☐ Urgent (recent trauma, pain, swelling)

Today's Date:_____/_____/_____

Patient Name: _____

DOB:_____/_____/_____ **Sex:** ☐ Male ☐ Female

Medicaid ID #:_____

Patient Phone #:_____

Patient Address: _____

_____

Parent/Guardian Name (for Pediatric referrals)

_____

Coverage:

☐ CareOregon Plus Child/Maternal

☐ CareOregon Plus Adult

Interpreter Needed?

☐ Yes ☐ No Language:_____

Referring Dentist:_____

Referring Clinic: _____

Clinic Phone: _____

Clinic Fax: _____

Specialty Type Requested:

☐ Endodontics ☐ Oral Surgery

☐ ENDS ☐ Pathology

☐ General Dentistry ☐ Pedodontics

☐ Hospital Dentistry ☐ Prosthodontics

Tooth/Teeth #: _____

Requested CDT Codes: _____

Treatment Needed: _____

_____

_____

_____

For partials, please list missing teeth #'s:

_____

_____

_____

For dentures, please indicate date of last extractions:

_____

Date:_____/_____/_____

Please include supporting documentation with referral request:

- Chart Notes
- Recent Periodontal Charting
- Dental Charting (existing and proposed)
- Treatment Plan
- Current and Pertinent Radiographs (or note if none available)
- Medical History

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Please email securely to
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