School of DENTISTRY
OHSU

OHSU Dental Clinics
Patient Referral Information

Date: _____

Please fill out all fields. Any missing information can delay the referral process.

Patient Name: _____ Date of Birth: _____

Patient Sex: ❑ Male ❑ Female ❑ _____ If interpreter needed, what language: _____

Phone: _____ Email: _____

Parent/Guarantor Name: _____ Relationship: _____

Address: _____ City, State, Zip: _____

Dental insurance: NAME_____ ID#/GROUP #_____

*OHSU Dental Clinics are participating with certain Oregon and Washington Medicaid dental plans. If you are referring a patient with Medicaid, please send a copy of the referral to the patient's dental plan.

❑ Copy sent to insurance plan. ❑ This is for Medicaid non-covered services, no insurance referral provided.

If urgent please specify a reason: _____

Tooth # / Area	Treatment Needed	Care Needed / Referral to Clinic:
		❑ Comprehensive Care ❑ Limited Care ❑ General Practice Residency ❑ Pediatric Dentistry ❑ Radiology ❑ Endodontics+ ❑ Faculty Dental Practice* ❑ Periodontics ❑ Oral Medicine/Orofacial Pain* ❑ Orthodontics ❑ Oral Maxillofacial Surgery ❑ Requested OMFS treatment is related to Orthodontics

*Please note that Faculty Practice and Oral Medicine do not offer reduced fees as OHSU Dental Clinics do, and they do not accept Oregon or Washington Medicaid plans. Cost of treatment will be out of pocket with Medicaid coverage and due at time of service.

+Diagnostic images are required for endodontic referrals. A periapical x-ray and bitewing is preferred, but pano will be accepted if only imaging available.

Relevant Medical History: _____

Does patient have severe medical condition or special needs? _____

Sedation requested? ❑ Y ❑ N If Yes, clinical need for sedation: _____

Other notes: _____

Implant Referrals: a current x-ray of the area is required. Please answer the following:

Has the tooth been extracted? ❑ Y ❑ N When? _____ Will you be restoring implant once placed? ❑ Y ❑ N

Requested implant system: ❑ Straumann (preferred) ❑ Nobel ❑ Bio Horizons ❑ Astra ❑ Zimmer ❑ Other: _____

REQUIRED:** (mark one)

❑ I am the dentist of record for the above patient and will see this patient for continued care.
Please evaluate and treat for the above, then return the patient to our office for other services.

-OR-

❑ This patient will need continuing care for all services at OHSU Dental Clinics.

REFERRING DOCTOR: *(please print)* _____

PRACTICE: _____

ADDRESS: _____

PHONE: _____ **FAX:** _____ **EMAIL:** _____

Referring Doctor Signature _____ Date _____

**In order for us to provide limited care to patients, we require documentation that treatment was diagnosed by a dental care provider, so we ask that you sign our referral form. We also ask that you indicate whether you will be seeing the patient for continuing care or would like the patient to seek continuing care with our clinics. If you would like to send someone to become a new patient, please have them call our main line to schedule a new patient exam at 503-494-8867.

Any missing information will delay treatment for your patient.

2730 S Moody Ave. Portland, OR 97201-5042 **Main Phone** 503-494-8867
Referrals Phone 503-346-4791 **FAX** 503-346-8232 **EMAIL** DentalReferrals@ohsu.edu

Please provide pertinent medical records and images.

Send all current, diagnostic images available:

- ✓ In jpeg format,
- ✓ Labeled with the Patient's Name,
- ✓ Date of birth,
- ✓ Date the images were taken, and
- ✓ Email to dentalreferrals@ohsu.edu,

Date X-rays taken: _____ Type of x-ray: _____

If you are unable to email them, please mail a disc to:

Dental Referrals Team
2730 S. Moody Avenue,
Portland, OR 97201
Phone: 503-346-4791
Fax: 503-346-8232

- ❑ Images are enclosed.
- ❑ Images are being sent.
- ❑ No X-rays available, please take radiographs.

Once your referral is received, the Referrals Team will route your referral to the appropriate clinic. Your patient will be contacted by the clinic to schedule an appointment. If further information is necessary, we will contact you.

Please note:

- ❖ **Diagnostic radiographs are required for endodontic referrals and preferred for implant referrals**. If images are not available, we may not be able to properly evaluate and accept your patient's referral.
- ❖ **If referring to Faculty Dental Practice:** FDP providers do not accept Oregon or Washington Medicaid and do not offer discounted rates on services.
- ❖ **If your referral was denied by Hospital Dental Services,** the referral still must be sent to our location to be processed. Referrals sent to Hospital Dental Services do not reach the OHSU Dental Clinics Referrals Team and are not automatically forwarded. We are at different locations.
- ❖ **If you have identified your patient's need for root canal therapy,** please do not send your patient to our Urgent Care Clinic. Urgent Care is for new, undiagnosed dental symptoms and not a place for referred patient triage.