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 #_____

*If patient is eligible with Medicaid, if referring for covered services please send a copy of the referral to the patient's dental plan.

Tooth # / Area	Treatment Needed	Care Needed / Referral to Clinic:
		❑ Comprehensive Care – all future treatment to be performed at SOD. ❑ Limited Restorative Care – only treatment requested; return for care ❑ General Practice Residency (for special needs and medically complex) ❑ Pediatric Dentistry (under 14) ❑ Endodontics ❑ Faculty Dental Practice* ❑ Periodontics ❑ Orthodontics ❑ Oral Radiology ❑ Oral Medicine/Orofacial Pain* ❑ Oral Maxillofacial Surgery –Is treatment related to Orthodontics? ❑ Y ❑ N *Private practice. / Does not accept Medicaid plans.

If urgent, please specify a reason: _____

If you have identified your patient's need for root canal therapy or an extraction, please do not have them call to schedule in our Urgent Care Clinic. Urgent Care is for new, undiagnosed dental symptoms.

BEHAVIORAL HISTORY:

Please note concerns if patient is unable to understand or consent to medical/dental procedures, or if they are combative during treatment. _____

MEDICAL HISTORY:

❑ Y ❑ N Patient has co-morbidities that require modified dental care.

Notes: _____

SEDATION:

❑ Y ❑ N Is sedation requested? Type of sedation: ❑ Oral sedation ❑ Nitrous oxide ❑ IV Sedation ❑ General Anesthesia

HISTORY: Patient has been successfully / unsuccessfully treated with: _____

Notes: _____

IMPLANT REFERRALS: A current x-ray of the area is required. Please answer the following:

❑ Y ❑ N The tooth has been extracted. When? _____

❑ Y ❑ N Will you be restoring implant once placed? If no, we will need all caries to be addressed first.

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

REQUIRED**: This information is required in order to provide treatment to patients. (Mark one)

❑ I am the dentist of record for this patient. Please evaluate and treat for the above, then return the patient for continued care.

❑ 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 the provider who diagnosed treatment to sign the referral form.

See next page. 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

Required information for referrals:

In order to provide **limited restorative care** including all crowns, bridges, implants, and removable partial dentures, all of the patient's caries will need to be addressed. We will also need the following:

Date of patient's **last exam:** _____

Date of the **last hygiene:** _____

Date **full set of X-rays taken:** _____

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

❑ No current X-rays available, please take radiographs.

Comprehensive or limited restorative care will require a full set of radiographs or panoramic x-ray.

Send all current, diagnostic images available:

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

If unable to email, please mail a disc to:
Dental Referrals Team
2730 S. Moody Avenue,
Portland, OR 97201
Phone: 503-346-4791

Images are being sent: ❑ By mail ❑ By email ❑ with patient (patient must bring to SOD so referral can be processed)

Information on Referral Processing:

Although you may have selected a specific clinic above, the Referrals Team will route the referral to the appropriate OHSU Dental Clinic to best serve the needs of the patient.

If further information is necessary, we will contact you. Your patient will be contacted by the clinic to schedule an appointment.

Please note:

- **Please note that Faculty Dental Practice and Oral Medicine do not offer reduced fees.** 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.
- **OHSU Dental Clinics are participating with certain Oregon and Washington Medicaid dental plans.** Most clinics are participating with Washington Apple Health dental plans, Oregon Health Plan Open Card, ODS Community Health, Capital Dental Care. If your patient has another state issued dental plan they will need a referral in order to be seen for covered services.
- **Diagnostic images are required for endodontic referrals.** A periapical x-ray and bitewing is preferred, but pano will be accepted if only imaging available.
- **Diagnostic radiographs and recent hygiene treatment history are required for implant referrals**. If images are not available, we may not be able to properly evaluate and accept your patient's referral.
- **All caries must be addressed before limited care treatment will be considered**.
- **If your referral was not accepted 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.