

We should receive, process, and review the referral within 2-4 weeks. We will reach out to the patient as soon as possible. If the patient is not scheduled within 6 months of this referral, we will request an updated referral before we will be able to schedule the patient.

**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: \* \_\_\_\_\_ ID#/GROUP # \_\_\_\_\_

\*For Medicaid patients, please send a copy of the referral to the patient's dental plan.  Referral sent.

Tooth # / Area	Treatment Needed	Referral to Clinic:
		Dental Student Clinic: <input type="checkbox"/> Limited Restorative Care <input type="checkbox"/> Comprehensive Care Specialty Clinics: <input type="checkbox"/> Endodontics <input type="checkbox"/> Orthodontics <input type="checkbox"/> Pediatric Dentistry (<14yo) <input type="checkbox"/> Periodontics <input type="checkbox"/> Advanced Adult Dentistry, General Practice Residency (for special needs and medically complex patients, please attach chart notes and indicate reason below) <input type="checkbox"/> Oral Maxillofacial Surgery –Is treatment related to Orthodontics? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Faculty Dental Practice* <input type="checkbox"/> Oral Medicine/Orofacial Pain* <small>*Private practice. / Does not accept Medicaid plans.</small>

**If urgent, please specify a reason:** \_\_\_\_\_

If you have identified necessary treatment, please do not have your patient call to schedule in our Urgent Care Clinic, which is for new, undiagnosed dental symptoms.

**BEHAVIORAL HISTORY:** Please note if patient is unable to give informed consent, or if they are combative during treatment.

**MEDICAL HISTORY:** Any pertinent health information requiring dental treatment modifications?  Y  N If Y, please describe: \_\_\_\_\_

**SEDATION:**  Y  N Is sedation requested? **Type:**  Oral sedation  Nitrous oxide  IV Sedation  General Anesthesia

**HISTORY:** Patient has been successfully / unsuccessfully treated with: \_\_\_\_\_

**Notes:** \_\_\_\_\_

**IMPLANT REFERRALS:** Please answer the following:

Y  N The tooth has been extracted. When? \_\_\_\_\_

Y  N Does the patient have adequate bone present in edentulous areas where implants are to be placed?

If no adequate bone is present, our provider should:  discuss treatment options with patient, or  return patient to our office.

Y  N Will you be restoring implant once placed?

If yes, which implant system:  Straumann (preferred)  Nobel  Bio Horizons  Astra  Zimmer  Other: \_\_\_\_\_

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

I am the dentist of record for this patient. Please return the patient to our office for continued care.

I will not be providing continuing care for this patient. Please transfer all care to 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.**

### Required information for limited restorative care referrals:

To provide **limited restorative care** including all crowns, bridges, implants, and removable partial dentures, please provide pertinent medical records and images, as below:

Date of patient's last exam: \_\_\_\_\_

Date of the last hygiene: \_\_\_\_\_ Hygiene recall schedule: \_\_\_\_\_

Date diagnostic imaging taken: \_\_\_\_\_ Date last X-rays taken: \_\_\_\_\_

Treatment completed in the last year: \_\_\_\_\_

---

#### Please send:

- Diagnostic Imaging - A full set of radiographs or panoramic x-ray and supplemental PA x-rays or bitewings.
- Latest periodontal charting
- Pertinent clinical notes

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

#### **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](mailto: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

#### 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 for Medicaid patients will be out of pocket 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, and Capital Dental Care. **If your patient has a state issued dental plan, they will need an approved insurance referral/authorization to be seen for covered services.**
- ❖ **Diagnostic images are required for endodontic referrals.** A periapical x-ray and bitewing are preferred, but pano will be accepted if only imaging available.
- ❖ **Before limited restorative care and implant treatment to be considered, periodontal issues and all active caries must be addressed (except those that are part of the referred treatment).**
- ❖ **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.
- ❖ **Oral Radiology provides CBCT scans and Imaging Interpretation Services.** For more information and a referral form, go to: [www.ohsu.edu/dental-clinics/oral-radiology](http://www.ohsu.edu/dental-clinics/oral-radiology).