School of DENTISTRY
OHSU

# OHSU Dental Clinics
# Patient Referral Information

Date: _____

**Referrals are valid for 6 months from 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: _____ Mobile? ❑ Y 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.

**Referral to:**

| **Dental Student Clinic:** | **Specialty Care Clinics:** | |
|---|---|---|
| ❑ Limited Restorative Care<br>Patients must complete all active periodontal treatment and caries treatment before being considered for limited care. A referral is required for all limited care services.<br>❑ General Dentistry<br>A referral is **not** required for patients seeking general dentistry services. Patients may call **503-494-8867** directly to schedule an appointment. | ❑ Endodontics<br>❑ Orthodontics<br>❑ Pediatric Dentistry (<14yo)<br>❑ Periodontics<br>❑ Oral Maxillofacial Surgery<br>–Is treatment related to Orthodontics? ❑ Y ❑ N | ❑ Faculty Dental Practice*<br>❑ FDP - TMD, Oral Medicine/Orofacial Pain*<br>*Private practice. / Does not accept Medicaid plans.<br>❑ Advanced Adult Dentistry, General Practice Residency (special needs patients; please attach chart notes and indicate reason below) |

| **Tooth # / Area** | **Treatment Needed** |
|---|---|
| | |
| **Required,** please choose one: | ❑ I am the dentist, or dental hygiene clinic, for this patient. Please return the patient to us for continued care.<br>❑ I will not be providing continuing care for this patient. Please transfer all care to OHSU Dental Clinics. |

**If urgent, please specify a reason:** _____

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, do you accept one of the SOD clinic available implant systems:

❑ Straumann (preferred) ❑ Nobel ❑ Astra ❑ No, I use another: _____

**REQUIRED.** **For us to provide limited care to patients, we require the provider who diagnosed treatment to sign the referral form.

**REFERRING DOCTOR:** *(please print)* _____

**PRACTICE:** _____

**ADDRESS:** _____

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

**Referring Doctor Signature** _____ Date _____

**See next page. Any missing information will delay treatment for your patient.**

## Required information for limited restorative care referrals:

For limited restorative care, the patient needs to have completed all active treatment. We cannot provide treatment if the patient has active caries, uncontrolled periodontal disease, or active infections.

**PLEASE CHECK BOX TO CONFIRM:**

❑ I confirm that patient has completed all active treatment and is ready for major restorative treatment.

For all crowns, bridges, implants, and removable partial dentures, please provide pertinent medical records and images:

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.

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:

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.

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.
- **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.
- **Referrals are valid for six months** from the date of form completion. If patient presents for treatment after that time, another referral will be required.