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: * _____ 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: ❑ Limited Restorative Care ❑ Comprehensive Care Specialty Clinics: ❑ Endodontics ❑ Orthodontics ❑ Pediatric Dentistry (<14yo) ❑ Periodontics ❑ Advanced Adult Dentistry, General Practice Residency (for special needs and medically complex patients, please attach chart notes and indicate reason below) ❑ Oral Maxillofacial Surgery –Is treatment related to Orthodontics? ❑ Y ❑ N ❑ Faculty Dental Practice* ❑ Oral Medicine/Orofacial Pain* *Private practice. / Does not accept Medicaid plans.

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 Will you be restoring implant once placed? If no, we will need all caries to be addressed first (see page 2 for details).

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.

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

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.

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.
- **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.
- **Periodontal issues and active caries must be addressed (except those that are part of referred treatment) before limited restorative 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.
- **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.