

Dental Referral Form



CareOregon
Dental

Priority: Routine Urgent (recent trauma, pain, swelling)

Today's Date: ____/____/____

Coverage:

Patient Name: _____

CareOregon Plus Child/Maternal

DOB: ____/____/____ Sex: Male Female

CareOregon Plus Adult

Medicaid ID #: _____

Interpreter Needed?

Patient Phone #: _____

Yes No Language: _____

Patient Address: _____

Referring Dentist: _____

Referring Clinic: _____

Parent/Guardian Name (for Pediatric referrals)

Clinic Phone: _____

Clinic Fax: _____

Specialty Type Requested:

- Endodontics Oral Surgery
 ENDS Pathology
 General Dentistry Pedodontics
 Hospital Dentistry Prosthodontics

Tooth/Teeth #: _____

Requested CDT Codes: _____

Treatment Needed: _____

For partials, please list missing teeth #'s:

For dentures, please indicate date of last extractions:

Date: ____/____/____

Please include supporting documentation with referral request:

- Chart Notes
- Recent Periodontal Charting
- Dental Charting (existing and proposed)
- Treatment Plan
- Current and Pertinent Radiographs (or note if none available)
- Medical History

CareOregon Dental

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Please email securely to
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