Dental Referral Form

Box must be filled out completely by person attending with member.

Member Name: ________________________________ **Date of Appt:** _____________

Name of Practice: ______________________________ **Time of Appt:** _____________

Doctor's Name: ____

Residential Provider/Staff Present: ____

□ **Pharmacy Verification:** ____

To be completed by dentist:

	Yes	No
Are there any decayed teeth?		
Is the gum tissue normal?		
Do the teeth show evidence of proper brushing?		
Is there obvious signs of infection?		
Are further x-rays needed?		
Should straightening of the teeth be considered?		
Are other abnormalities present other than malocclusion?		

Treatment Orders:

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□ **Generic equivalent acceptable** □ **Medication Covered by Insurance**

Provider Signature ____

Next appt. scheduled for: Date: ___________ **Time:** ________ **In Therap** □

Per Medicaid standards, all medication orders need to include:
Name, Dosage (cannot be a range), Form, Route, Time (cannot be a range)
Order example:
Cephalexin 500mg tablet. Take 1 tablet by mouth every 6 hours for 7 days.

Independent PCA ONLY:
Weight: ______lbs. BP ____/_____ Other Vitals: ____________ In Therap □