



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:

Generic equivalent acceptable

Medication Covered by Medicaid/Medicare

Medical 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.