



Dental Treatment Referral Form

Request date: _____ Requestor name: _____

Requestor title: _____ Requestor email: _____

Organization name: _____ Phone: _____ Fax: _____

Organization type (check one): School SBHC County health ER Pediatrician's office
(referrals NOT accepted from Parent/legal Guardian, must come directly from authorized organization)

1. Child's personal information:

Last name: _____ First: _____ MI: _____

Child's date of birth: _____ Gender: M F Primary language: _____

a. Address: _____

City: _____ State: _____ ZIP: _____ Co: _____

b. Preferred daytime phone: _____

c. Name of parent or legal guardian: _____

d. Is the child 5 to 18 years of age? Yes No

2. Child's dental information:

a. Primary reason for referral: Pain (abscess) Tooth pain (unknown cause)
 Restorative (cavity) Preventative

b. Is the child a patient of record of a local dentist? Yes No Unknown

c. If yes, list dentist's name: _____ City: _____

d. Is child covered under a dental plan? OHP Commercial None Unknown

e. Has the child been referred to this program in the past? Yes No Unknown

f. Has child's parent or legal guardian been notified of this referral? Yes No
Referring party is responsible for notifying parent that child is being referred to The Children's Program

The Children's Program provides access to basic dental services on an **as-needed basis** for uninsured children ages 5 to 18 who reside in Oregon. If eligible, each child will be assigned a dentist and may receive care during his or her eligibility period. The child's parent or legal guardian will receive a letter notifying them of the child's ID number and dentist's name and phone # so they may schedule an appointment. The assigned dental office will also receive a copy of the referral letter.

PLEASE FAX COMPLETED REFERRAL FORM TO 503-382-5342 OR 888-229-7140. For more information, please contact The Children's Program Coordinator at 503-265-5627 or 888-393-2772, or E-mail childrensprogram@odscompanies.com.

FOR OFFICE USE ONLY		<input type="checkbox"/> Accepted	<input type="checkbox"/> Pending additional information
<input type="checkbox"/> Does not qualify (reason: _____)		<input type="checkbox"/> Member on file (prev. referral)	
<input type="checkbox"/> Current coverage checked <input type="checkbox"/> O <input type="checkbox"/> F		Assigned: <input type="checkbox"/> ODS <input type="checkbox"/> WDG <input type="checkbox"/> KZ	
Assigned dentist: _____		P. no.: _____	
<input type="checkbox"/> Notified referring organization	Referral processed (date and initial):	TCP _____	B&E _____