

MORE Care

Dental Referral Treatment Report

PATIENT INFORMATION:	Patient Name:	DOB:	Phone: Fax: Email:
	Address:		
DENTAL CARE REPORT:	Date of Dental Appt:	Did patient keep their scheduled appointment? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is all needed treatment completed? <input type="checkbox"/> Yes <input type="checkbox"/> No
	List any prescription agents given to patient:		
	Patient's Oral Health Diagnosis: <input type="checkbox"/> Abscess/Infection [K12.2] <input type="checkbox"/> Periodontitis [K05.6] <input type="checkbox"/> Caries Activity/Decay [K02.9] <input type="checkbox"/> Gingivitis [K05.1] <input type="checkbox"/> Other: _____		Oral Health Risk Status: <input type="checkbox"/> ELEVATED <input type="checkbox"/> MODERATE <input type="checkbox"/> LOW
	Date of Patient's Next Dental Appointment: ____ / ____ / ____	Additional Notation:	
PATIENT SELF-MANAGEMENT GOALS:	Oral health self-management goal recommendations:		
DENTAL CARE TEAM:	Date: ____ / ____ / ____	Dental Provider:	Dental Provider Phone #:
	Dental Provider Signature:		