MORE Care

Medical Provider Referral for Dental Care

Referral Type: [ ] Emergent [ ] Urgent [ ] Direct *Maintanence referrals don't require this form

REFERRING PROVIDER REPORT:

Provider:	Practice Name	Phone: Fax: Email:
Address:		

PATIENT INFORMATION:

Patient Name:	Patient DOB:	Phone: Email:
Address:		Parent(s) Name:

☐ Male
☐ Female

Insurance Information:
☐ Self Pay/No Coverage
☐ Medicaid (ID #: _____)
☐ Commercial (Name: _____)

PATIENT MEDICAL INFORMATION:

Abbreviated Medical History: *[Please provide dental team recent H & P and medication list when applicable]*

Date of Last Fluoride Application: _____/_____/_____ Fluoride Supplements Prescribed: ☐ Yes ☐ No	Allergies:	Any prescriptions provided specific to the patient's oral issues?

PATIENT SOCIAL HEALTH BARRIERS:

Identified social health barriers [select all that apply]:

- ☐ Food Insecurity
- ☐ Housing Instability and Homelessness
- ☐ Inadequate Housing
- ☐ Transportation Insecurity
- ☐ Financial Strain
- ☐ Social Isolation
- ☐ Stress
- ☐ Interpersonal Violence
- ☐ Education
- ☐ Employment
- ☐ Veteran Status

If known, please provide relevant ICD Z codes:

REASON FOR REFERRAL:

Reason for Referral [Select all that apply]:

- ☐ **Abscess/Infection [K12.2]**
- ☐ Caries Activity/Decay [K02.9]
- ☐ Gingivitis [K05.1]
- ☐ Diabetes
- ☐ Periodontitis [K05.6]
- ☐ Significant Plaque/Tartar/Calculus
- ☐ Pregnant
- ☐ Other: _____

PATIENT SELF-MANAGEMENT GOALS:

Oral health self-management goal recommendations:

INTERNAL USE (REFERRAL TRACKING):

Date Referral Sent:	Referring Dental Provider:	Date of Referral Follow Up:

I am the patient or parent/guardian of the patient. I consent to this medical provider sharing information about me / my child with the dentist/dental care team named. I also consent to the dentist/dental care team sharing information about me / my child with this medical provider.

Signature: _____ Date: _____