



Community Health, Inc.

Dental Referral Request Form

OHP

Plan: PLUS STANDARD Is Emergency Treatment Needed? YES NO

OHP Client ID#: _____ DOB: ____ / ____ / ____

Patient Last Name: _____ First: _____ M.I.: _____

Address: _____

City/State: _____ Zip Code: _____

Patient's phone: _____

Name of Current General Dentist & Clinic: _____

Address: _____

City/State: _____ Zip Code: _____

Phone: _____ Fax: _____

Date of last appointment: ____ / ____ / ____ Is the patient experiencing pain? YES NO

Has pain relief been provided? YES NO Any medications given? YES NO

Please indicate medications given or any other type of relief provided: _____

Type of specialty referral requested. **Tooth #:**
 ENDO O.S. PERIO PEDO GENERAL DENTIST

What type of x-rays are available?
 PA Bitewing How many? _____ Full Mouth Panorama

Does the patient require a language interpreter?
 YES NO Language needed: _____

For ENDO treatment, please indicate if the canals are: Curved Calcified

For OS treatment, please indicate below any other treatment is needed.

For PERIO treatment, please note pocket depths & any bone loss below along with most recent Perio chart.

Additional information regarding patient's special needs, condition of tooth or teeth, ect:

For ODS use only Eligibility Information: _____

ODS CSR - Call/Fax received by: _____ Date call/Fax received: _____

Referral To: _____ Date Letter sent to member and provider: _____

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