Orthodontic Referral
Oral Health and Hygiene Assessment

This form must be completed by the referring dentist and forwarded to the evaluating orthodontist.

RECIPIENT INFORMATION	
Recipient Name _____	Recipient Medical Assistance ID _____

REFERRING DENTIST INFORMATION	
Referring Dentist Name _____	Referring Dentist Provider ID _____

Oral Health and Hygiene Assessment (This section must be completed and signed by the referring dentist.)	
Referring Dentist Name:_____	Referring Dentist Provider ID:_____ψ

At least one of the following conditions must be met before a referral to an orthodontist is made.

The recipient named above is referred for orthodontic evaluation: (check one)

☐ for treatment of cleft palate.

☐ and presented for a caries-free initial visit or has had all decayed teeth restored and has remained caries free for at least six months; **and** demonstrates oral hygiene adequate to begin and successfully complete orthodontic services.

To the best of my knowledge, the above information is true, accurate, and complete.

_____ _____

Signature of Referring Dentist Date

NOTE: This form must be submitted by the requesting orthodontist as part of the orthodontic service authorization request.

(rev. 07/2015)