



ORAL

Oregon Rural Alliance of Dental Leadership

1966 Garden Ave Eugene Or 97403
Phone: 1-866-935-9663 Fax: (541) 342 1150 Clinic:1-866-492-2701

ORAL Referral Form

Please write clearly and legibly

Client Information

Client Name: _____ CARE Ware Number _____

Address: _____

Birthdate: _____ Client Phone #: _____

Overall Acuity: _____ Dental Acuity: _____ Percentage of Federal Poverty Level: _____ %

Case Manager: _____ Phone #: _____

County: _____ Agency: _____

- Client needs assistance filling out paperwork
- Client is Spanish speaking and will need an interpreter.

Health Care Information

Physician Client
sees for HIV Care: _____ Phone #: _____

Pharmacy: _____ Phone#: _____

Insurance: _____ OHP Plus _____ OHP Standard _____

Please mark the services for which the patient is being referred.

- Exam and assessment
- Pain and/or infection
- Restorative work
- Denture or Bridge work
- Other _____

Medical History: Please indicate any applicable conditions below.

- Diabetes
- Heart valve or joint replacement
- Uses a blood thinning agent
- Hypertension
- Other Concerns: _____

Additional Notes: _____
