



Orthodontia Patient Referral Form
(Codes D8070, D8080, D8090, D8091)

Date _____ Valid From _____ To _____ Referral # _____

Patient Name _____ Medical ID _____ DOB _____

Address _____ City/State _____ Zip _____

Parent/Guardian Name _____ Home # _____ Work # _____

PCD Name _____ Office Phone _____

Office Address _____ City/State _____ Zip _____

Please check the box below which best describes the member's condition:

- Member has cleft lip and cleft palate, or cleft palate or cleft lip with alveolar process involvement** – attach supporting documentation from member's primary medical care provider
- Member has craniofacial anomaly resulting in significant malocclusion expected to result in difficulty with mastication, speech, or other oral function**– attach supporting documentation from member's primary medical care provider
- Member has severe malocclusion with a Handicapping Labiolingual Deviation (HLD) Index California Modification score of 26 and higher.**

Please complete the following items:

- Attach progress notes and health history from most recent exam.
- Current Pano
- Completed Cavity Clearance form
- I attest that this member is free of decay and periodontal disease, verified by a dental exam within the prior 6 months.

Date of exam _____

You MUST provide labelled orthodontic study models with bite registration in digital or analog format with this request.

PCD Signature _____ Date _____

<p style="text-align: center;"><u>For Use By CDC Staff Only:</u></p> <p>Referred To: _____</p> <p>Address: _____</p> <p>City/State: _____</p> <p>Zip Code: _____</p>	<p>Primary determination:</p> <p>EPSDT Review:</p>
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Orthodontist Completes

Orthodontist: _____ Location: _____ Fax # _____

Patient Name: _____ Ortho Account #: _____ Age _____

Notes from Orthodontist: _____

Do not treat the following teeth: _____

Orthodontist's Signature: _____ Date: _____

To be completed by the General Dentist/Pediatric Dentist

Exam Date: _____ GP Account #: _____

Perio Stage (circle one): 0 I II III IV

Hygiene (circle one): Poor Good Excellent

Perio Grade (circle one): A B C

Cleaning Date: _____

Plaque Present (circle one): Yes No

Type (circle one) Prophy SRP Perio maint

Bleeding/inflammation (circle one): Yes No

Planned Hygiene Interval (months): 6 4 3 Next Hygiene Due/Scheduled Date: _____

Hygiene/ Periodontal Clearance (select one):

- For Pre-Ortho: **OK to Start Ortho** – Hygiene/Perio is stable and ortho may begin
 Delayed – Hygiene/Perio is not yet stable, ortho may not begin until _____
 NOT CLEARED – Hygiene/Perio is not stable, **ortho should not begin**

- Ortho in Progress: **OK to Continue Ortho** – Hygiene/Perio stable
 Guarded – Hygiene/Perio fair/poor - ortho may continue with close monitoring
 Not Cleared – Hygiene/Perio poor, please **pause/discontinue ortho**

Restorative (“Cavity”) Clearance (select one):

- For Pre-Ortho: **OK to Start Ortho** – Restorative stable, ortho may begin
 OK to Start Ortho – Minor restorative Tx needed - to be completed concurrently with ortho (list below), ortho may begin
 Delayed – Restorative Tx needed – ortho may not begin until completed
 NOT CLEARED – Caries risk too high, **ortho should not be started**

- Ortho in Progress: **OK to Continue Ortho** – Restorative stable
 Guarded – Caries risk high, will monitor closely
 Not Cleared – Caries risk too high, please **pause/discontinue ortho**

Notes from General Dentist: _____

GP Name: _____ Office: _____

GP Signature: _____ Date: _____

Instructions for the General Dentist: Please complete all areas and check one applicable box from the Hygiene/Periodontal Clearance section and check one applicable box from the Restorative (“Cavity”) Clearance section. Please also sign and date. Any other information you wish to share can be entered in the Notes from General Dentist area. Please fax to the number in the top right area. Thank you!