MAP-556

KENTUCKY MEDICAL ASSISTANCE PROGRAM
Orthodontic Referral Form
Patient in Active Treatment

This form allows you to type your information through Acrobat Reader. To save the form (use a personalized file name) on your local drive so that you can return to your form, if need be. When you are finished, print the form and mail to the address below.

Date: _____

TO: _____ FROM: _____

_____

_____

Patient's Name: _____ MAID#: _____ Age: _____

Responsible Party: _____

Address: _____

Case Analysis and Treatment Plan: _____

_____

Original active treatment time estimate _____

Appliances _____

Variations (i.e. torque, slots, angle, etc.) _____

_____

Date bands and/or brackets cemented _____ Cementing medium _____

Current Archwire Sizes: Upper _____ Lower _____

Headgear: Type _____ Hours requested _____

Intraoral elastics _____

Size and make _____ Hours requested _____

Force direction _____ Force value _____

Removable appliance: Type _____ Hours requested _____

Force direction _____ Force value _____

Removable appliance: Type _____ Hours requested _____

Patient Cooperation:

Oral hygiene _____

Headgear _____

Elastics _____

Appointments _____

Patient attitude toward treatment _____

Suggestions for Patient Motivation _____

General Remarks:

Progress to date _____

_____

Recommendations for further treatment and/or additional comments _____

_____

Transfer of Records:

No records were obtained _____

Records being forwarded under separate cover _____

Contact our office after patient arrives and we will forward records _____

Our records include:

Models _____ Cephalograms _____ Tracings _____ Intraoral radiographs _____

Photographs _____ Intraoral Photographs _____ Facial Photographs _____

RESET

EDS
Prior Authorization Unit
P.O. Box 2103
Frankfort, Kentucky 40602