Medically Necessary Dental Prosthetics Referral Form

Inmate Name: _____ TDCJ # _____

Facility: _____ City _____

DOB: _____ Sex: _____ Race: _____

Requested Procedure/Treatment: (Dentures and/or Removable Partial Dentures)

_____

Dental Diagnosis: (Please include pertinent dental history i.e. … edentulous, partially edentulous, length of time with compromised masticatory function.)

_____
_____
_____
_____
_____
_____

Medical Diagnosis: (Please include pertinent clinical history ie,.. weight loss, digestive disorders, laboratory and x-ray findings.)

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_____

Medical/Dental Reason for Request: (Adverse outcomes if request denied)

_____
_____
_____

Alternative Treatment Modalities: (Diet, medications etc.)

_____
_____
_____

Dentist Signature: _____ Date: _____

Physician Signature: _____ Date: _____