Virginia Department of Behavioral Health & Developmental Services

Referral for Dental Services

This form must be filled out completely and submitted by the Individual's CSB Representative. Incomplete forms will be returned to the CSB Representative. Return this form to DentalTeam@dbhds.virginia.gov. Forms will ONLY be accepted by email unless prior arrangements have been made with Dental Management.

Date of Request:	Date of Birth:
Individual's Name:	Preferred Name:

☐ This individual has an intellectual or developmental disability as defined by the VA Code

Level of Intellectual/Developmental Disability: ☐ Profound ☐ Severe ☐ Moderate ☐ Mild

☐ This individual is in need of Dental Care

Date of their last dental visit: _____

If specific date is unknown, please list how long it has been since their last dental visit. This field cannot be left blank or listed as "Unknown."

Does the individual have Medicaid? ☐ Yes ☐ No

If yes, what Managed Care Organization (MCO) have they selected?

☐ Aetna ☐ Anthem ☐ Magellan ☐ Optima ☐ United Healthcare ☐ Virginia Premier ☐ None

Has the individual been able to secure a dental appointment with the MCO plan if applicable? ☐ Yes ☐ No

What were the barriers that kept the individual from using their MCO plan? _____

_____

Does the individual require any type of sedation for their dental visits? ☐ Yes ☐ No ☐ Unsure

Is this individual a previous resident or previously received services at any Virginia Training Center? ☐ Yes ☐ No

If yes, what Virginia Training Center?

☐ CVTC ☐ NVTC ☐ SEVTC ☐ SVTC/Hiram ☐ SWVTC

Community Service Board:	
Community Service Board Representative:	
Phone Number:	Email:

CSB Representative Signature: _____ **Date:** _____

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☐ Region 1 ☐ Region 2 ☐ Region 3 ☐ Region 4 ☐ Region 5

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CLIENT INFORMATION

Indicate individual's type of residence: ☐ Family Home ☐ Group Home ☐ ICF

Name of Group Home/ICF (if applicable):	
Street Address:	Apt/Suite:
City/Town:	Zip Code:

Is the individual his or her own legal guardian? ☐ Yes ☐ No		
Legal Guardian/Authorized Representative (if applicable):		
Phone:	Email:	
Residential Care Provider (if different from Legal Guardian):		
Phone:	Email:	
Emergency Contact:		Relationship:
Phone:	Email:	

DAY SUPPORT INFORMATION

Does the individual attend a Day Program? ☐ Yes ☐ No

Day Program Name:	
Street Address:	
City/Town:	Zip Code:
Days and Hours of Attendance:	

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MEDICAL INFORMATION

Medical Diagnosis:

Prescribed Medications:

Allergies (please describe reaction):

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CAPABILITIES

Is the individual ambulatory? ☐ Yes ☐ No
If no, does the individual use one of the following? ☐ Power Wheelchair ☐ Manual Wheelchair ☐ Walker ☐ Bed ridden ☐ Other _____ **Wheelchair Width from wheel to wheel:** _____
How does the individual communicate? ☐ Non-verbal ☐ Verbal ☐ Gestures ☐ Manual Signing ☐ Vocalizations ☐ Other Communicative Devices _____
Does the individual have any sensory impairments? ☐ Deaf ☐ Partially Deaf ☐ Blind ☐ Partially Blind
Does the individual require staff assistance? ☐ Total Staff Assistance ☐ Mostly Staff Assistance ☐ Minimal Staff Assistance ☐ Independent

Additional Patient Considerations (include likes, dislikes, previous experiences, concerns):

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This individual's referral to the DBHDS Dental Program has been: ☐ Approved ☐ Denied

Referred To: _____

Phone Number to schedule appointment: _____

Address: _____

City/State: _____

Approved by: _____ Date: _____