NCSD Oral Health Program
6031 SE King Road, Milwaukie, Oregon 97222
503-353-6096 office
smilesquad@nclack.k12.or.us

REFERRAL FORM

NCSD Oral Health Program

return completed form to: smilesquad@nclack.k12.or.us
(for N. Clackamas School District students)

Date of Request: _____

Person referring student: _____

Relationship to student: _____

Phone number(s): _____

Student Name: _____ Grade: _____

School: _____ Teacher: _____

Parent/Guardian Name: _____

Relationship to Student: _____

Phone Number(s): _____

Email(s): _____

Does the student have dental insurance: ❒ OHP ❒ Other Dental Insurance ❒ None

Reason for referral (check all that apply):

Is the student having dental pain? ❒ Yes ❒ No

Does the student have: ❒ swelling/abscess ❒ broken tooth/teeth ❒ pain

Assistance needed (check all that apply):

☐ Finding a dentist

☐ Signing up for dental insurance coverage (navigation help)

☐ Other _____

Questions
503-353-6096 | smilesquad@nclack.k12.or.us