



CSHCN ORTHODONTIC SERVICES REQUEST FORM

ORTHODONTIST Name _____
Mailing Address _____

APPLICANT Last Name _____ First Name _____ Date of Birth _____
Parent/Guardian Name _____
Mailing Address _____
Daytime Phone _____

SCREENING QUESTIONS To be completed by licensed orthodontist. Record all measurements in order with teeth in centric position. Round to nearest millimeter.

1. Class II OVERJET in millimeters (positive numbers only), measured from facial lower incisor to facial upper incisor	_____ mm x 3 = _____	<i>Minimum qualifying screening score is 35 points. Exceptions made for children with medically documented cranio-facial anomalies including:</i> <ul style="list-style-type: none"> • Cleft lip or palate; • Pierre-Robin sequence; • Hemifacial or craniofacial microsomia; • Crouzon, Apert, or Treacher-Collins syndrome; and • Condylar aplasia.
2. OVERBITE in millimeters (positive numbers only), measured from upper incisal edge to lower incisal edge	_____ mm x 2 = _____	
3. Class III REVERSE or NEGATIVE OVERJET in millimeters measured from facial upper incisor to facial lower incisor	_____ mm x 5 = _____	
4. ANTERIOR OPEN BITE in millimeters measured from incisal edge to incisal edge	_____ mm x 4 = _____	
5. Number of radiographically documented IMPACTED TEETH excluding 3 rd molars, crowded and/or blocked out teeth (PANOREX required)	_____ teeth x 5 = _____	
6a. Number of arches with MODERATE CROWDING (< 6 millimeters)	_____ arches x 2 = _____	
6b. Number of arches with SEVERE CROWDING (>6 millimeters)	_____ arches x 4 = _____	
7a. Number of upper permanent teeth in ANTERIOR CROSS BITE	_____	
7b. Number of upper permanent teeth in POSTERIOR CROSS BITE	_____	
8. Number of habits affecting arch development (describe below)	X 2 = _____	
TOTAL SCORE _____		

DENTITION Transitional Adolescent Adult

DOCUMENTATION ATTACHED Cephalogram (must be original image with imbedded measurement scale or notation of image scale.)
(Photos and cephalogram required. All images will be returned.) Panorex (required for impacted teeth) Photographs (high quality facial and intra-oral)

REQUEST Interceptive treatment Comprehensive treatment following interceptive treatment Comprehensive treatment only

SCREENING ORTHODONTIST COMMENTS

SCREENING ORTHODONTIST SIGNATURE _____ Date _____

RETURN COMPLETED FORM TO REGIONAL CSHCN OFFICE OR CALL 803-898-0784 FOR ASSISTANCE

DHEC USE ONLY

<input type="checkbox"/> Information insufficient to determine eligibility	<input type="checkbox"/> Does not meet clinical requirements for orthodontic services
<input type="checkbox"/> Approved for INTERCEPTIVE treatment	<input type="checkbox"/> Approved for COMPREHENSIVE treatment after interceptive treatment
<input type="checkbox"/> Approved for COMPREHENSIVE treatment only	

COMMENTS

_____ Date _____ _____ Date _____
CSHCN Orthodontic Consultant Signature CSHCN Program Office Signature

INSTRUCTIONS

TITLE

Children with Special Health Care Needs (CSHCN) Program Orthodontic Services Request Form (DHEC 0762)

PURPOSE

This form is used by licensed orthodontists and DHEC staff to submit information necessary to determine clinical eligibility for CSHCN orthodontic services.

ITEM-by-ITEM INSTRUCTIONS

1. Orthodontist information: Enter name of referring orthodontist enters name and mailing address (this is address to be used for provider correspondence).
2. Patient information:
 - a. Enter name and date of birth of the person to receive orthodontic services.
 - b. Enter name, address and phone number of parent or guardian.
3. Screening questions, documentation, requested services and comments completed by referring orthodontist, who will sign and date the form before submitting to DHEC.
4. CSHCN Program staff or consultants will complete "DHEC USE ONLY" section in accordance with applicable policies by checking appropriate boxes, signing and dating the form.
5. Copies of completed form are sent to submitting orthodontist, and submitting regional CSHCN office.

OFFICE MECHANICS AND FILING

The completed form is filed on the left side of the health care record behind the "Correspondence/Other" tabbed divider in chronological order, most recent on top. Retention schedule and destruction same as for DHEC Health Records.