7327 SW Barnes Rd. #219
Portland, Oregon 97225

www.SmileOregon.org
info@smileoregon.org

Craniofacial Team's Information:

1. Team name: ____________________

2. Primary contact person:

   First: ____________________ Last: ____________________

3. Phone number: ____________________ example (XXX)-XXX-XXXX

4. Email address: ____________________

5. Address:

   Street address, P.O. Box, c/o: ____________________

   Apartment, suite, unit, building, floor, etc.: ____________________

   City, State, Zip Code: ____________________

Patient's Information:

6. Patient's Name

   First: ____________________ Last: ____________________

7. Patient's Birth Date: ____________________
   (MM/DD/YYYY)

8. Diagnosis(es)/Condition(s):

9. Relevant Medical History Statement:

To coordinate comprehensive care and support for
the children and families of Oregon who are affected
by Cleft Lip and Palate and other Craniofacial conditions

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10. Proposed Treatment Plan:

11. How does the proposed treatment plan integrate with the patient's overall team care?

12. Proposed Start Date:

13. Estimated Length of Treatment:

14. Other comments:

Craniofacial Team's Statement:

As a team we are willing to work closely with Smile Oregon's medical advisory committee. We understand that we may be requested to submit periodic progress reports, final records and follow-up records.
As a team we agree to the above statement, related to Smile Oregon policies, and we are stating that the information contained within the application is, to the best of our knowledge, true and accurate.

15. Signature____ Date:_________________________

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