

Postgraduate Endodontics Referral Form

Date of referral: ____/____/____

Referring dentist: _____ **Name of Practice** _____

Office telephone: (____) _____ - _____ **Office e-mail:** _____

Patient name: _____

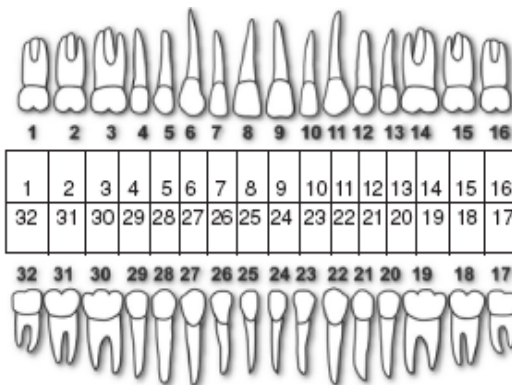
Parent/Guardian name if minor: _____

Patient telephone: (____) _____ - _____ **Patient e-mail:** _____

Tooth number or area: _____

Reason for Referral:

- Consultation
- Root canal treatment
- Root canal re-treatment
- Apical surgery
- Vital pulp therapy, revascularization, or apexification
- Other _____



Medical and Dental History:

- Negative
- Significant _____
- Patient may require nitrous oxide or oral sedation
- Special needs _____

Restorability and periodontal status:

- Tooth has been evaluated for restorability and periodontal support
- Crown lengthening may be needed after RCT
- Post space requested

- Patient is to return to referring dentist for all restorative and periodontal therapy
- Patient is to remain at the UIC College of Dentistry for all remaining dental care

Other comments:
