ENDODONTICS
COLLEGE
OF DENTISTRY

801 S. Paulina Room 313
Chicago, IL 60612
Tel: 312-355-3615 **Fax**: 312-996-9500
endodontics@uic.edu

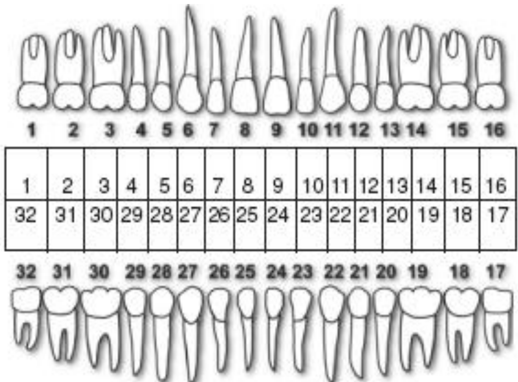
Postgraduate Endodontics Referral Form

Date of referral: _____/______/_______

Referring dentist:________________________________ Name of Practice ___________________________
Office telephone: (_______)_________-___________ Office e-mail: ______________________________

Patient name: ____
Patient date of birth:_____________________________
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:

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(09/16/2016)