ENDODONTICS
COLLEGE
OF DENTISTRY

Changing the Future of Oral Health

UIC COLLEGE OF DENTISTRY PATIENT REFERRAL

Please provide all of the information below and fax/email this form to:

DEPARTMENT OF ENDODONTICS ROOM 313
801 S PAULINA ST CHICAGO, IL 60612
312-996-9500 (Fax) | 312-355-3615 (Office)
endodontics@uic.edu

Date of Referral: _____

Referring Practice/Provider:

Practice: _____ Provider/Doctor: _____

Phone: _____ Email: _____

Patient Information:

Patient Name: _____ DOB: _____ Gender: _____

Parent/Guardian (if patient is minor): _____

Phone: _____ Email: _____

Insurance Plan/Provider: _____

Reason(s) for referral (check all that apply):

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

Medical and Dental History:

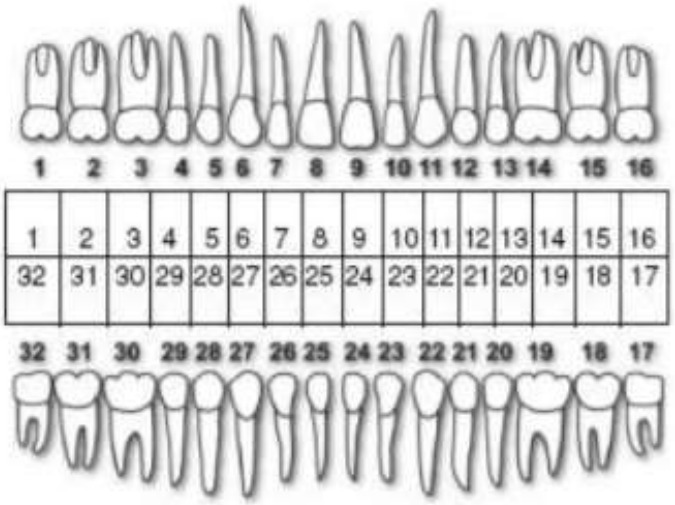
☐ Negative ☐ Significant
☐ May require nitrous oxide or oral sedation
☐ Special needs

Restorability and periodontal status:

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

☐ Patient will return to referring dentist
☐ Patient will remain with UIC

Tooth/Region Number _____



Please indicate if available:

☐ Panoramic X-rays ☒ Full mouth series
☐ CT Scan

Additional Comments:

_____

_____

_____

This form is available online at dentistry.uic.edu/patients/resources