School of Dental Medicine
UNIVERSITY OF COLORADO ANSCHUTZ MEDICAL CAMPUS

Email SDM

ENDODONTIC LIMITED CARE REFERRAL FORM

Please email this completed form along with all relevant radiographs to sdmreferral@ucdenver.edu or fax to (303) 724-0600

Please note that the First appointment will be an evaluation only.

Patient Information:

Name:_____ **DOB:**_____**Address:**_____

Contact Number:_____ **Language:**_____ **Interpreter needed:** ◯ **Yes** ◯ **No** **Patient in pain?** ◯ **Yes** ◯ **No**

Reason for Referral:

- ☐ **Endo Limited Care: RCT only for tooth #**_____
- ☐ **Endo Limited Care: RCT & Build Up (excluding post) for tooth #**_____
- ☐ **No build up needed but please leave a post space**

Criteria for Preliminary Qualification for Limited Care (must be completed for consideration)

	Qualifies		Does not Qualify
Mouth Opening:	☐ **3-4 Fingers**	☐	**2 Fingers**
Gag Reflex:	☐ **NO**	☐	**YES**
Medical Condition:	☐ **ASA 1-2**	☐	**ASA 3-4**
Tooth:	☐ **I / C / PM/ 1M**	☐	**2nd Molar**
Crown:	☐ **NO**	☐	**YES**
Previously Treated:	☐ **NO**	☐	**YES**
Canal Curvature:	☐ **<20◦**	☐	**>20◦**
Patient willing to attend multiple appointments	☐ **YES**	☐	**NO**
Patient willing to be treated by students	☐ **YES**	☐	**NO**
Radiographic Appearance:	☐ **Visible pulp chamber**	☐	**Diminished pulp chamber**
Crown lengthening needed or suspected	☐ **NO**	☐	**YES**
Severe dental phobia or dental anxiety	☐ **NO**	☐	**YES**

Referral from:

Dentist:_____**Clinic/ACTS Site:**_____

Phone:_____**Fax/Email:**_____

Signature of Referring Dentist:_____ **Date:**_____

For any questions regarding Endodontic services, scheduling, or referral follow-up, feel free to contact the Endodontics Program Coordinator at (303) 724-3946.