School of Dental Medicine
UNIVERSITY OF COLORADO ANSCHUTZ MEDICAL CAMPUS

# ENDODONTIC LIMITED CARE REFERRAL FORM

**Please email this form and all relevant radiographs to sdmreferral@cuanschutz.edu or fax to (303) 724-0600**

**First appointment will be an evaluation only**

## Patient Information:

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

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

## 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:_____**

**ENDO20**