SCHOOL OF DENTISTRY
UNIVERSITY of WASHINGTON

Clear Form

Department of Endodontics
Box 357448
Seattle WA 98195-7448
PH 206-543-3995
https://dental.washington.edu/endodontics/

**IMPORTANT**

A recent periapical of diagnostic quality must be submitted with all referrals. Please email* this form and your PA to: referral@uw.edu

*HIPAA requires using encrypted email pathways when emailing patient information.*

***Faxed and mailed referrals will not be accepted.**

For more information, please consult our referral policy at:
https://dental.washington.edu/referral-email-policy/

**Date of referral:** _____

**WE REQUIRE THE COMPLETION OF ALL FIELDS IN ORDER TO PROCESS YOUR REFERRAL IN A TIMELY MANNER**

| PATIENT INFORMATION | | | |
|---|---|---|---|
| Patient Name | | Date of Birth | |
| Address (street, city, state, and zip code) | | | |
| Home Phone | Cell Phone | | E-mail |
| Dental Insurance (please list) | | Provider One ID # | |
| Guardian or Power of Attorney | Contact Person Name | Contact Person Home Phone | Contact Person Cell Phone |
| Interpreter needed Y☐N ☐<br>Language | | | |

| REFERRAL INFORMATION | | |
|---|---|---|
| Referred by (provider and facility name) | Provider Phone | Provider Fax |
| Address (street, city, state, and zip code) | | Provider Email |

**The patient is referred to the UW Endodontic Clinic for:**

☐ Consultation
☐ Root canal treatment
☐ Root canal re-treatment
☐ Endodontic Surgery
☐ Post space preparation
☐ Intracoronal Bleaching

☐ Other services _____

☐ CBCT (please specify area) _____

**Tooth #** _____

Description of the problem: _____

Clinical Examination performed:

Vitality tests _____ Pos ____ Neg _____ Palpation _____ Pos _____ Neg

percussion _____ Pos ____ Neg _____ Mobility _____ Pos _____ Neg

Perio Probing: _____

Radiographic Findings: _____

Diagnosis (differential): _____

Description of Tx. Already Performed: _____

**NOTE: If this box is left blank a temporary filling will be placed and the patient will be returned to your clinic for final restoration.**

☐ Please indicate if you would like the Restorative Department to place the final restoration following completion of endodontic treatment.

_____

Signature of Referring Dentist