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

***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 ☐ 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