SCHOOL OF DENTISTRY
UNIVERSITY of WASHINGTON

Department of Endodontics
Box 357448
Seattle WA 98195-7448
PH 206-543- 5034 FX 206-616-9786
https://dental.washington.edu/endodontics/root-canals/

IMPORTANT

A recent periapical must be submitted with all referrals. We are unable to accept bitewing or Panorex images, digital images must be of diagnostic quality

Clear Form

☐ PA mailed with copy of this form
☐ PA emailed to referral@uw.edu *

*Please consult our referral email policy
https://dental.washington.edu/referral-email-policy/

Date of referral: _____

WE REQUIRE THE COMPLETION OF ALL FIELDS IN ORDER TO PROCESS 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)		

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