University of Pittsburgh School of Dental Medicine

Department of Endodontics

Referral Form for Endodontic Treatment

This page is to be completed ONLY by the referring dentist. Please FAX to our office: 412-383-9478

Patient Name:_____ Phone:_____

Referring dentist information:

Name of practice: _____

Referring dentist: _____

Phone number: _____

Address: _____

_____

_____

Information relative to treatment:

Area/tooth of concern: _____

Proposed restorative treatment for this area: _____

_____

Recent/relative dental history pertaining to chief complaint: _____

_____

Please check treatment requested:

☐ Address chief complaint and treat as necessary

☐ Evaluate for endodontic retreatment

☐ Evaluate for apical surgery

☐ Elective endodontics. All restorative and periodontal therapy will be addressed in the referring practice

☐ Patient is to remain at the School of Dental Medicine for all remaining dental care

Referring dentist signature: _____ **Date:** _____

University of Pittsburgh

3501 Terrace Street, Pittsburgh, PA., 15261-4024

Phone: 412-648-8616 | FAX: 412-383-9478