School of Dental Medicine
UNIVERSITY OF COLORADO ANSCHUTZ MEDICAL CAMPUS

Email SDM

ENDODONTIC LIMITED CARE REFERRAL FORM

Please email this form and all relevant radiographs to sdmreferral@ucdenver.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?** ◯ **Yes** ◯ **No**

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 (OFFER EXIPRES MAY 1, 2020)