Post Graduate Endodontics Program
Dept of Preventative and Restorative Dental Sciences
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EndodonticClinic@ucsf.edu

UCSF POST GRADUATE ENDODONTIC CLINIC EXTERNAL REFERRAL FORM

Please complete both sides of the referral form. Incomplete referrals will be returned to referring provider.

DATE: _____

REFERRING PROVIDER INFORMATION
Doctor's Name: _____
Office Phone Number: _____
Office Name and Address: _____
_____

PATIENT INFORMATION
Patient's Name: _____
Date of Birth: _____ Phone Number: _____
Patient Address: _____
_____

INSURANCE INFORMATION
Dental Insurance Name: _____
Insurance ID Number: _____
Subscriber Name: _____ Subscriber DOB: _____

REFERRAL INFORMATION

Tooth #: _____

Is the tooth restorable? ☐ YES ☐ NO

Pulpal Diagnosis

_____ Normal

_____ Reversible Pulpitis

_____ Irreversible Pulpitis

_____ Necrosis

Periadicular Diagnosis

_____ Normal

_____ Acute perirdicular periodontitis

_____ Chronic perirdicular periodontitis

_____ Acute perirdicular abcess

_____ Evaluation Only

_____ Nonsurgical root canal treatment

_____ Post space preparation

_____ Amalgam build up

_____ Return unrestored, temporary filling & cotton only

_____ Evaluation and Appropriate Treatment

_____ Nonsurgical root canal treatment

_____ Prefabricated post

_____ Composite build up

_____ Endodontic surgery

Does a post need to be placed ☐ YES ☐ NO

Will the patient be returning to referring provider for the remaining restorative work? ☐ YES ☐ NO

If yes, please provide details for the restorative plan.

_____

_____

Additional Comments:

_____

_____

Please include any current x-rays (FMX, PA or bite wings) related to patient's treatment with this form.

_____

Referring Doctor's Signature

Please send complete form via fax 415-476-6173 or email EndodonticsClinic@ucsf.edu