UNIVERSITY OF ALBERTA
FACULTY OF MEDICINE & DENTISTRY
School of Dentistry

# ORAL HEALTH CLINIC
# DDS PROGRAM – ENDODONTICS
## Patient Referral and Screening Information

**Referring Clinic:** _____ **Date:** _____

Last Name: _____ First Name: _____ Gender: _____

DOB (D/M/Y): _____ Parent/Guardian Name: _____

Home Address: _____ City: _____ Prov.: _____ Postal Code: _____

Home phone #:_____ Cell phone #: _____

Dental Insurance: yes ◉ no ○

If yes, policy and employee number: _____

Patient is being referred for root canal treatment in tooth # _____

**Additional information:**

| | | |
|---|---|---|
| ☐ Asymptomatic | ☐ Spontaneous pain | ☐ Periapical radiolucency |
| ☐ Thermal sensitivity | ☐ Swelling | ☐ Exposed pulp |
| ☐ Biting sensitivity | ☐ Fracture | ☐ RCT was initiated |

☐ Medical conditions: _____

**The patient will be referred back, with a temporary coronal restoration, unless otherwise is requested.*

Additional information:

Dr: _____ Signature:_____

*Please fax this form to (780) 407-5694.*