UNIVERSITY OF ALBERTA

ENDODONTICS
DDS Program
Referral Form

Fully complete forms should be faxed to 780.407.5694 or sent to dentappt@ualberta.ca; a copy should be saved at the referring office.

Date

PATIENT INFO

Patient's name

Birthdate (MM/DD/YYYY)

Gender

Parent/guardian name

Preferred phone

PHN

Alternate phone

Email

Insurance policy #

Insurance employee #

Address

REFERRED BY

Name

Email

Office phone

Fax

Address

Signature

REASON FOR REFERRAL

Root canal treatment in tooth #

Additional information

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

Patients will be assigned to a DDS student who, under the supervision of a licensed faculty member, will complete endodontic assessments and treatment. The patient will be referred back to your clinic with a temporary coronal restoration, unless requested otherwise.

The Canadian Dental Care Plan is accepted.

Mike Petryk School of Dentistry
Kaye Edmonton Clinic - Level 8
11400 University Ave, Edmonton, AB T6G 1Z1

T 780.407.5550
F 780.407.5694
dentappt@ualberta.ca
uab.ca/clinic