



UMKC School of Dentistry

Patient Referrals
650 E. 25th St.
Kansas City, MO 64108
Phone: (816) 235-2116

All referrals must be emailed
Xrays and referral must be in same email
Email: umkcdentalrecords@umkc.edu

Date: _____

Referring Dentist

Name: _____

Phone: _____

Fax: _____

Email: _____

Completed Case Report Requested: ___ Yes ___ No

Clinic: Comprehensive Care (Patient call 816-235-2100 to schedule)
(circle one) Endodontics (BW & PA required)
Periodontics (FMX required)
Oral & Maxillofacial Radiology
Pediatrics
Orthodontics

Diagnostic x-rays with exposure dates must be sent in a JPG format

Patient Information

Name _____ Date of Birth _____

Guardian Name (if patient is under 18) _____ Preferred Language _____

Phone # _____ Secondary Contact _____

Referral Information

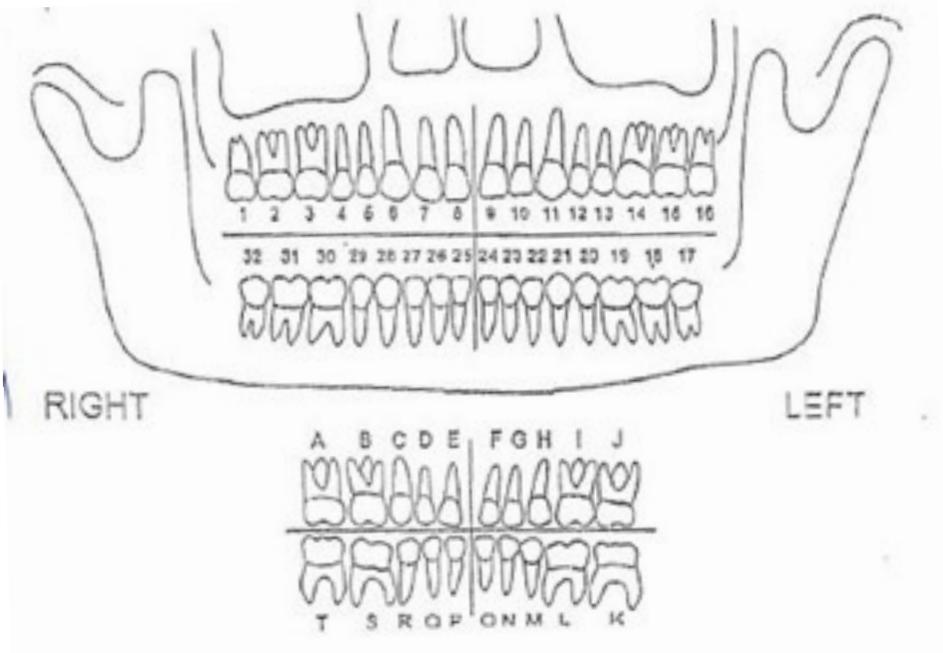
Tooth#/Site _____ Requested Treatment _____

Detailed Chief Complaint Required (or treatment notes with endo testing results) _____

Referrals for Endo treatment _____ Place Buildup _____ Post Prep _____ Place Post & Core _____

Diagnostic x-rays with exposure dates must be sent in a JPG format

****Incomplete referrals will be returned****



Patient is returning to referring doctor for restorative/continued care? YES NO

Patient may be referred to Pre-doc clinic for referred treatment? YES NO

All requested information must be provided before patient is contacted.

****Incomplete referrals will be returned****