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: ______________

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

Referring Dentist

Name: ______________________________
Phone: ______________________________
Fax: ______________________________
Email: ______________________________
Completed Case Report Requested: ____Yes____No

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)*______________________
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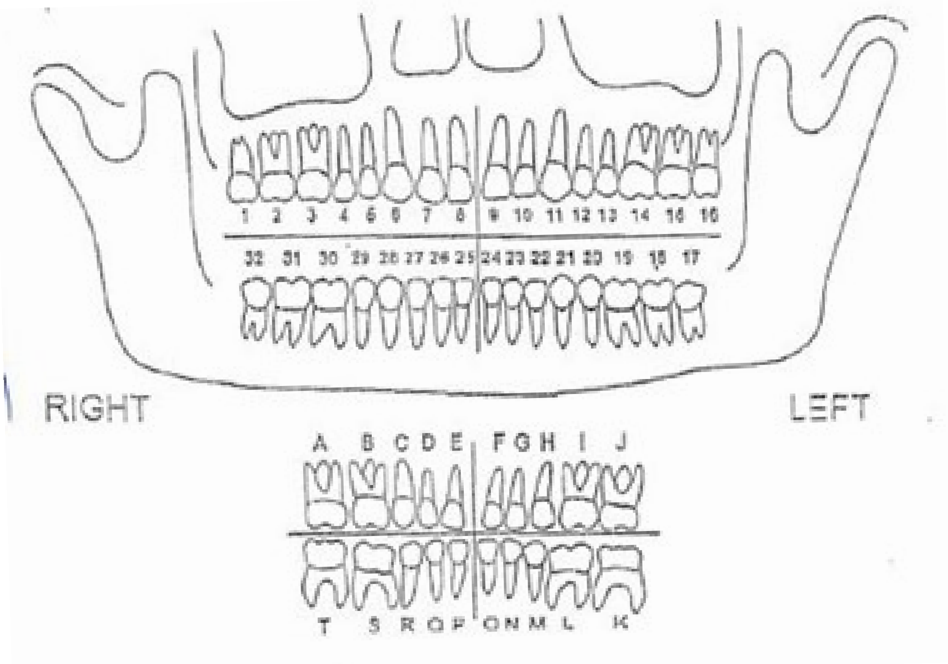
Referrals for Endo treatment ____________Place Buildup ____________Post Prep ______________Place Post & Core

Include both of the following: Medical History Diagnostic x-rays *(sent by email in JPG format with exposure dates)*

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****