UMKC School of Dentistry
Patient Referrals
650 E. 25th St.
Kansas City, MO 64108

Phone: (816) 235-2116
Fax: (816) 235-5322
Email: umkcdentalrecords@umkc.edu

Date: _____

Clinic: *(circle one)*
Comprehensive Care
Advanced Education in General Dentistry
Endodontics
Oral Surgery
Oral & Maxillofacial Radiology
Pediatrics
Periodontics

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 Phone _____

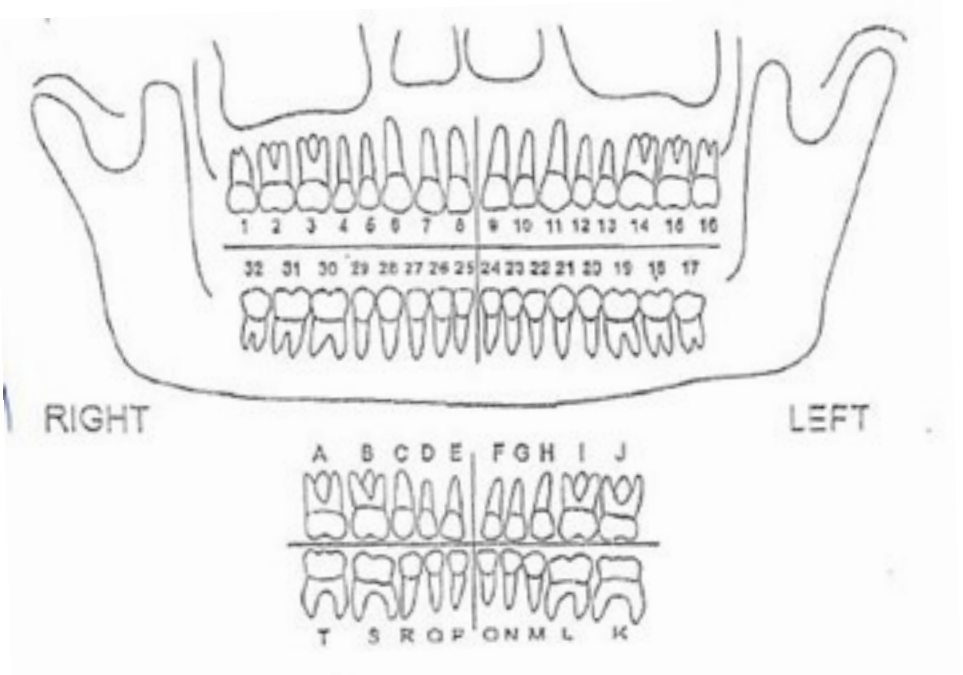
Referral Information

Tooth#/Site_____ Chief Complaint _____
Treatment *(as requested)* _____
_____
Reason for referral _____
_____

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 referral will delay treatment



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 delay treatment****