School of Dental Medicine
UNIVERSITY OF COLORADO **ANSCHUTZ MEDICAL CAMPUS**

# Dental Referral Form

Please email this form filled out COMPLETELY* and all relevant radiographs to sdmreferral@cuanschutz.edu or fax to (303) 724-0600.

**First appointment will be an evaluation only**

*Referral will not be accepted if patient information and treatment needs are not completely filled out; OS and Endo referrals will not be accepted without x-rays.

**This Referral Is:** ☐ Emergent (send patient to ED) ☐ Urgent (24-72 hours) ☐ Routine (next available)

**Type of dental care needed**: ☐ Comprehensive Care ☐ Limited care

**Patient Information**

Name: _____ DOB: _____

Gender Identity: ☐ Male ☐ Female ☐ Transgender ☐ Other Language: _____ Interpreter needed: ☐ Y ☐ N

Street address: _____ City: _____ State: _____ Zip code: _____

Contact Number: _____ Health First Colorado # (Medicaid): _____

Parent/Guardian/Caretaker Name: _____

Last Exam Date: _____ Last Cleaning Date: _____

☐ X-rays mailed/emailed, date taken: _____ ☐ Need X-rays
(please send X-rays to sdmreferral@ucdenver.edu)

**Reason for Referral:**

☐ Crowns
☐ Bridges (not limited care)
☐ Denture: Complete
☐ Denture: Partial
☐ Denture: Overdenture
☐ Endo: RCT only
☐ Endo: RCT, Permanent Restoration/Crown
☐ Periodontal Care
☐ Implants: Surgical only
☐ Implants: Surgical and Restorative
☐ Orthodontic care
☐ Extractions
☐ Sedation Needs: _____
☐ Special needs (please specify type and reason):
_____
Patient is ☐ verbal ☐ non-verbal.

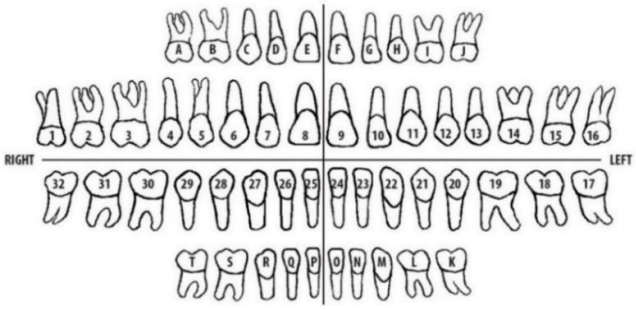
☐ Complex medical needs: _____

☐ Other/Detailed instructions: _____

_____

_____

Please circle below the tooth/teeth of referral:




**Referral from:**

Dentist: _____ Clinic/ACTS Site: _____

Address: _____

Phone: _____ Fax/ Email: _____

Signature of Referring Dentist: _____ Date: _____