MARQUETTE UNIVERSITY SCHOOL OF DENTISTRY ENDODONTIC DEPARTMENT

1801 W. Wisconsin Ave., Milwaukee, WI 53233

Phone: 414-288-7047 Fax: 414-288-6510

PLEASE USE THIS REFERRAL FORM EXCLUSIVELY

Date: _____

Patient Name: _____

Patient Phone: _____ Date of Birth: _____

Insurance: _____ (Please submit pre-auth when necessary) A Panorex or FMX MUST BE SENT to our office for Title 19 patients over the age of 21 requiring molar RCTs. Radiographs can be emailed to dentalendo@marquette.edu.

Tooth number: _____

	1 2 3 4 5 6 7 8	9 10 11 12 13 14 15 16
R		L
	32 31 30 29 28 27 26 25	24 23 22 21 20 19 18 17

Please select:

Root Canal Therapy_____ Retreatment_____ Consultation_____ Surgery ____

Other: _____

Comments/Notes:

Please note: Before treatment can be done at MUSoD, we require knowing that the patient has made arrangements for the final restoration. **Check** below if arrangements have been made and that the patient understands he/she needs to return to your office for the final restoration. _____

1. Do you require a post space? _____
2. Do you desire to do your own core? _____

If you answer yes to either question, we will send the patient back with a simple resin seal.

Referred by: (please print) _____

Signature: _____

Office name, phone and fax number:

_____

** It is the patient's responsibility to check on their referral/preauthorization by calling us. Forward Health HMO's take approximately 3-4 weeks from the time they are submitted until they get to our office. **