UNIVERSITY OF LOUISVILLE
SCHOOL OF DENTISTRY

501 South Preston Street
Louisville, Kentucky 40292
Phone: (502) 852-5096
Fax: (502) 852-1110

Limited Treatment and Consultation Referral Form

Referral Dentist & Office

Dentist's Name: _____ Date: _____ (mm/dd/yyyy)

Office Name: _____ Office Phone: _____ (Area Code Number) Fax: _____ (Number)

Office Address: _____ (Street City State Zip Code)

Patient Information Gender: ☐ **M** ☐ **F**

Patient's Name: _____ (Last First M) DOB: _____ (mm/dd/yyyy)

Home Address: _____ (Street City State Zip Code)

Phone Cell: _____ (Area Code Number) Phone Home: _____ (Area Code Number)

Will this patient return to your office for comprehensive care? ..... ☐ Yes ☐ No

Will this patient return to your office for final restoration? ..... ☐ Yes ☐ No

Is this case urgent (EMERGENCY)? ..... ☐ Yes ☐ No

Will radiographs be provided? ..... ☐ Yes ☐ No

If you have patient radiographs, either digital or film-based, please provide copies prior to the patient's consultation appointment. Digital radiographs of high-quality are preferred; however, all formats are accepted. Mail copies to:

Records Room, University of Louisville School of Dentistry, 501 South Preston Street, Louisville, KY 40292-0001

X-Rays can be SECURE emailed to: dentalca@louisville.edu

Please fax any additional information related to the patient's case to: (502) 852-1110

Referral Information

☐ RCT	☐ Oral Surgery and/or Biopsy	☐ Implant placement only
☐ Crown/Bridge	☐ TMD/Facial Pain	☐ Implant placement & restoration
☐ Extraction only	☐ Ridge Augmentation	☐ Periodontal treatment
☐ Extraction/Preservation	☐ Sinus Lift	☐ Other (specify)

Reason for referral/diagnosis:

Special Accommodations:

*****Requested consultation/treatment (specify, including special instructions):**

It is **IMPORTANT** that **ALL** information is filled-out accurately in order to process this referral and avoid delays in care.