OU College of Dentistry
Patient Referral for Limited Treatment in Student Clinics

**PLEASE COMPLETE ALL INFORMATION**

Patient Name: _____ DOB: _____ Today's Date: _____

Parent Name (if patient is a minor): _____

Patient Address: _____ City_____ State_____ Zip_____

Phone Number: _____ Home Cell Work (circle one)

**Referring Entity**:

Referring Dentist Name: _____

Office Address: _____
Street City State Zip

Office Phone: _____ Email: _____

**Reason for Referral:** (Please Circle All Applicable)

1. Referring entity does not provide this type of treatment.
2. Patient financial considerations.
3. Other reason: _____

**If this referral is for an extraction(s), please call Oral Surgery directly at 405-271-4079**

**Treatment Requested:**

☐ **Endo (PA required for each tooth requested) Tooth #_____**

☐ **Crown (PA AND BW required for each tooth requested) Tooth # _____**

☐ **Other _____ (PA/BW and Pano Required) Tooth #_____**

E-mail jpeg digital images securely with form to *Sabrina-Savage@ouhsc.edu* or mail this form with x-rays to:
**Sabrina Savage - OU College of Dentistry - 1201 N Stonewall Ave Suite 238 Oklahoma City, OK 73117**

**Date of Patient's Last Visit and Tx Performed:** _____

**Student Preference** (if applicable): _____

**My signature verifies that this patient is currently receiving comprehensive treatment in my practice and that I will provide the recommended follow-up care indicated.** I understand and agree that the College of Dentistry faculty may decline the referral based on treatment complexity or recommend that the patient be screened and accepted for comprehensive care as a patient at the College of Dentistry in order to complete the treatment requested if it is in the patient's best interest to do so.

**Referring Dentist's Signature:** _____

**College of Dentistry Use Only**

**Date**:_____ **Student Name**:_____ **PSC**:_____ **Dx Code**:_741469__

☐ Root Canal Anterior (D3310) Tooth #____ $182.00 ☐ Root Canal, Pre-molar (D3320) Tooth #____ $225.00

☐ Root Canal Molar (D3330) Tooth #_____ $273.00 ☐ Pre-fab Post & Core (D295) Tooth #_____ $85.00

☐ Crown, Tooth #_____ $500.00 ☐ Other, _____Tooth #_____

***Always collect Pre-payment for Endo and enter a general note into the EHR!***

Initiated 04/09 Revised 6/20, 5/22