OU College of Dentistry
Office of Patient Management
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)

Is the patient listed above a current established patient in your practice? *Yes Or No* (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: _____

Treatment Requested: **Tooth #_____☐Endo** **Tooth #_____☐Crown**
Tooth #_____☐Extraction **_____☐Other**

Digital image must be e-mail 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**:_____

☐ Root Canal Anterior, D3310, Tooth #____ $161.00 ☐ Root Canal, Pre-molar, D3320, Tooth #____ $196.00

☐ Root Canal Molar, D3330, Tooth #___ $263.00 ☐ Pre-fab Post & Core, D2954, Tooth #___ $76.00

☐ Crown, Tooth #____ ☐ Other, _____Tooth #___

X-Rays: ☐Scan into axiUm ☐ Take to Radiology ☐ Email Sabrina once pt. is entered into axiUm

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

Initiated 04/09 Revised 10/14, 2/16, 2/17, 9/18, 6/19