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

Dental Referral Form

Please email this form and all relevant radiographs to sdmreferral@ucdenver.edu or fax to (303) 724-0600.
For cases involving pain, please call (303) 724-5571 upon sending referral and X-rays.

First appointment will be an evaluation only

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

Patient Information

Name: ____________________ DOB: ____________

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

Address: ____________________

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:

☐ Comprehensive care
☐ Crowns
☐ Bridges
☐ 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: ____________________

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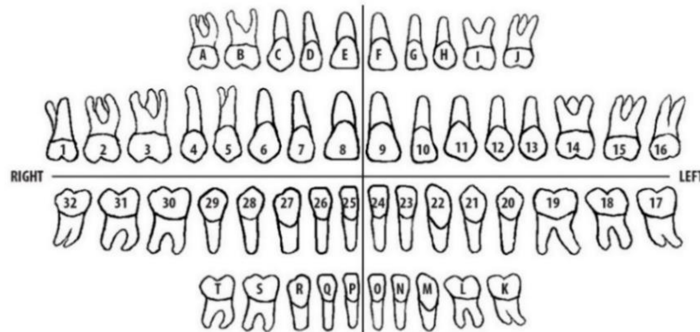
Please circle below the tooth/teeth of referral:



Referral from:

Dentist: ____________________ Clinic/ACTS Site: ____________________

Address: ____________________

Phone: ____________________ Fax/ Email: ____________________

Signature of Referring Dentist: ____________________ Date: ____________