SAINT LOUIS UNIVERSITY
Endodontics and Periodontics

Patient Information

First name: _____
Last name: _____
DOB: _____ Age: _____
Phone: _____
Last appointment date: _____

Referring Dentist Information

Referred by: _____
Phone: _____
Email: _____
Address: _____

Please send the following X-Rays, if available:

Perio:

- FMX or panoramic within last 5 years
- BWs

Endo:

- Periapical images (recently taken)

Please email xrays to endoref@health.slu.edu
Do x-rays need to be taken? _____ Yes _____ No

Patient referred for the following reasons:

Periodontics:

_____ Periodontal evaluation (____ full ____ limited)
_____ Implant evaluation/placement
Tooth# _____
Preferred implant system: _____
_____ Recession or gum grafting
_____ Bone grafting/ridge augmentation for implants
_____ Expose and bond
_____ Frenectomy
_____ Guided Tissue Regeneration
_____ Peri-implantitis
_____ Crown lengthening (pre-prosthetic or esthetic)
_____ Terminal dentition/FME with implants

Periodontal treatment history:

_____ None _____ SRP (UL UR LL LR)
_____ Prophy _____ Perio maintenance
_____ Other

Possible extractions?

- Have you advised the patient of the possibility of tooth extraction? ____ Yes ____ No
- If yes, what tooth numbers? _____

Is there any restorative dentistry that needs to be completed? Does the patient have a restorative treatment plan? Please provide details:

_____
_____
_____

Endodontics:

Tooth/teeth that need to be evaluated: _____
Reason for referral:

_____ Pain or swelling
_____ Radiographic findings
_____ Carious pulp exposure
_____ History of trauma
_____ Root canal needed for restorative reasons
_____ Other _____
_____ Suspected cracked tooth
_____ Vital pulp therapy/regeneration
_____ Tooth has been previously opened

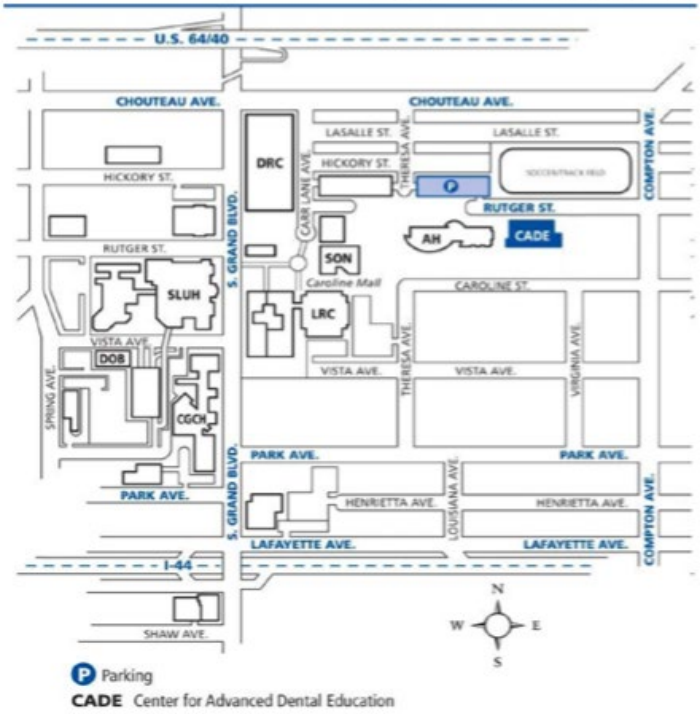
Requested treatment:

_____ Evaluation only
_____ Root canal therapy
_____ Root canal re-treatment
_____ Apical surgery
_____ CBCT
_____ Post space only requested
_____ Place the permanent post and/or core buildup
_____ Call to discuss prior to treatment Best phone number and time: _____

Comments:

_____
_____

Please send a copy of this form with the patient and email a copy to endoref@health.slu.edu. We greatly appreciate your referral!



-Our clinic (CADE) is located in Dreiling-Marshall Hall, which is the building across from the track.

-You will receive a parking ticket when you enter the garage. Please bring that with you to be validated at your appointment.

-Once in the building, walk past the orthodontic clinic and follow the signs for the Periodontics/Endodontics clinic.

Scan this code with your camera for directions.