Resident Specialty Services
Treatment Referral Form
(to be completed only by referring dentist)

Patient Name ________________________________________________________ Phone ________________________________________________

Referring dentist information
Name of practice ____________________________________________________ Phone _____________________________________________

Name of referring dentist _____________________________________________________________________________________

Address __________________________________________________________________________________________________________

________________________________________________________________________________________________________________

Information relative to treatment
Area/tooth of concern _____________________________________________________________________________________________

Recent/relative dental history pertaining to chief complaint __________________________________________________________________________________________

________________________________________________________________________________________________________________

________________________________________________________________________________________________________________

Additional comments or instructions on proposed dental treatment _________________________________________________________

________________________________________________________________________________________________________________

Signature of referring dentist ____________________________________________ Date ______________________________

Please check treatment requested and identify plan for comprehensive care

ENDODONTICS
____ Address chief complaint & treat as necessary
____ Evaluate for endodontic retreatment
____ Evaluate for apical surgery
____ Elective endodontics
____ Prepare for post space
____ Other ____________________________

____ All restorative and periodontal therapy will be addressed in the referring practice
____ Patient is to remain at Pitt Dental Medicine for all remaining dental care

PERIODONTICS
____ Address chief complaint & treat as necessary
____ Evaluate for periodontal treatment
____ Evaluate for implant therapy
____ Crown elongation
____ Soft tissue grafting
____ Impacted tooth exposure
____ Gingivectomy
____ Frenectomy/supracrestal fiberotomy
____ Other ____________________________

____ All treatments other than periodontal therapy will be addressed in the referring practice
____ Patient is to remain at Pitt Dental Medicine for all remaining dental care

ORTHODONTICS
____ Evaluate for early/interceptive treatment
____ Evaluate for comprehensive treatment
____ Evaluate for pre-prosthetic treatment
____ Evaluate for orthodontics and surgical treatment
____ Other ____________________________

____ All other dental care will be addressed in the referring practice
____ Patient is to remain at Pitt Dental Medicine for all remaining dental care

Pitt Dental Medicine
Residency Specialty Services
3501 Terrace Street
Pittsburgh, PA 15261-4024
412-648-2110

Please fax your completed form to the appropriate department

Endodontics 412-383-9478
Periodontics 412-648-8594
Orthodontics 412-648-8817

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