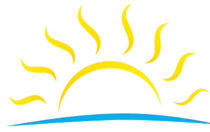

Endodontic Referral

Referring Dental Practitioner

Name ____________________
Address ____________________
____
Postcode ____________________
Tel ____________________
Fax ____________________
Email ____________________
Date ____ /____ /____

Patient Details

Name ____________________
Address ____________________
____
Postcode ____________________
Home ____________________
Work ____________________
Mob ____________________
DoB ____ /____ /____

Relevant Medical History (including any medication and allergies)

____
____

Dental History (please tick)

☐ Patient new to your practice ☐ Regular attender

Reason For Referral (please tick)

☐ Consultation
☐ Root Treatment
☐ Re-Root Treatment
☐ Post Removal
☐ Trauma
☐ Perforation/Root Resorption Treatment
☐ Instrument Removal
☐ Apexification/Apical Plug
☐ Endodontic Surgery (consultation required)
☐ Other (please specify) ____________________
____
____

Tooth Notation (please circle)

8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8

Enclosures

☐ X-rays Please include any radiographs which may help in evaluating the patient. We will return them to you after use.
☐ Photographs
☐ Others

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