Endodontic Referral Form

PATIENT INFORMATION:

Today's Date _____

First Name _____ Last Name _____ Date of Birth _____

Parent / Guardian Name _____ Insurance _____

Contact Telephone _____ Contact E-Mail Address _____

Does the patient require antibiotics prior to dental treatment? ❑ Yes ❑ No • ❑ Patient will call for appointment ❑ Please call patient

Treatment _____

REFERRING DOCTOR'S INFORMATION:

Referred By _____ Telephone _____

E-Mail Address _____

FOR CONSIDERATION FOR CONSULTATION AND /OR ENDODONTIC TREATMENT:

Please indicate tooth / area to evaluate _____

REFERRED FOR THE FOLLOWING:

- ❑ Consultation and Diagnosis
- ❑ Root Canal Treatment
- ❑ Re–Treatment
- ❑ Apicoectomy / Retrograde
- ❑ Apicoectomy / Retrofilling
- ❑ Pulp Exposure
- ❑ Buildup
- ❑ Post and Crown Buildup
- ❑ Tooth is Open for Drainage
- ❑ Endodontic Microsurgery
- ❑ Extraction / Surgical Removal
- ❑ Implants:
  - ❑ Immediate ❑ Delayed
- ❑ Pre-Prosthetic Surgery
- ❑ Leave Post Space
- ❑ Remove Post
- ❑ Perform Post Space
- ❑ Orthograde Endodontic Therapy
- ❑ Select Canal(s)

PATIENT STATUS:

Frequency of Discomfort . . ❑ None ❑ Occasional ❑ Constant

Nature of Discomfort . . . . . ❑ None ❑ Vague ❑ Mild ❑ Moderate ❑ Severe

Preferences . . . . . ❑ Examination and Diagnosis only ❑ Examination, Diagnosis and Treatment

OTHER INFORMATION:

❑ Please send additional referral pads

❑ **Please call me:**

Crown / Bridge is Cemented:

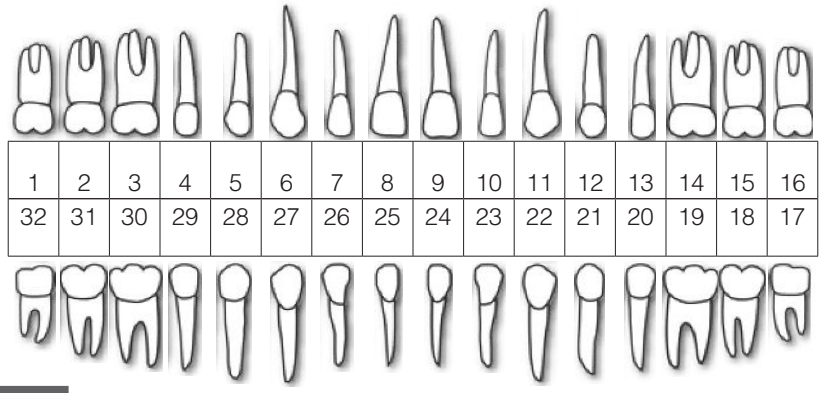
RADIOGRAPHS OR CLINICAL PHOTOS:

- ❑ Being Mailed
- ❑ Given To Patient
- ❑ Please Take
- ❑ No X–Ray
- ❑ Attached With This Referral; if X-Rays are attached, what date were they taken _____

TO ATTACH X-RAY(S) TO THIS REFERRAL FORM PLEASE SUBMIT THE FORM ABOVE OR BELOW.

AFTER THE FORM IS SUBMITTED YOU WILL THEN HAVE THE OPTION TO UPLOAD X-RAYS THAT WILL BE ATTACHED TO THIS REFERRAL FORM.

PLEASE MARK TEETH / AREA TO BE TREATED:



1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

POSSIBLE EXTRACTIONS:

Have you advised the patient of the possibility of extraction? If so, which tooth number(s) _____

CASE NOTES: