Endodontic Referral

If possible please provide a periapical radiograph

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Patient's Name ______________________ D.O.B. __________ Phone(s) ______________
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Address ____

Appt. Day and Time ____________________ Referring Dentist ____________________

Comments ____

Tooth Status

- ❑ Discomfort or emergency
- ❑ Asymptomatic
- ❑ Periapical lesion
- ❑ Exposure / large carious lesion
- ❑ Recent restoration
- ❑ Endo started
- ❑ Previous failing RCT

Endo Services Required

- ❑ Emergency care
- ❑ Consultation
- ❑ Root Canal Treatment
- ❑ Elective RCT (Prosthetic, Perio. reason)
- ❑ Non-Surgical Retreatment
- ❑ Second Opinion
- ❑ Other

After Root Canal Treatment

- ❑ Temporise and return
- ❑ Prepare post space(s)
- ❑ Other

Tooth / teeth