# Endodontic Referral Form

dental referral

## REFERRING DENTIST

Name: _____ Tel: _____

Address: _____ Fax: _____

_____ Email: _____

Post code: _____ Date: ____/____/____

## PATIENT DETAILS

Name: _____ Home Tel: _____

Address: _____ Work: _____

_____ Mob: _____

Post code: _____ D.O.B.: ____/____/____

Is this referral urgent? ☐ Yes ☐ No

## RELEVANT MEDICAL HISTORY (Any additional comments about this referral)

## TYPE OF REFERRAL (Please tick)

☐ Patient new to your practice ☐ Regular Attender

## REASON FOR REFERRAL (Please tick/specify)

☐ Consultation ☐ Location of Canals ☐ Re-Root Treatment

☐ Post Removal ☐ Trauma ☐ Potential Root Fracture

☐ Perforation/Root Resorption Treatment ☐ Instrumental Removal ☐ Post & Core Build Up

☐ Endondontic Surgery (consultation required)

## SYMPTOMS (Please tick/specify)

☐ Pain ☐ Acute ☐ Chronic

☐ Unknown Aetiology ☐ Swelling ☐ Mobility

☐ Difficulty Chewing

## TOOTH NOTATION

| RIGHT | | | | | | | | LEFT | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ☐ 18 | ☐ 17 | ☐ 16 | ☐ 15 | ☐ 14 | ☐ 13 | ☐ 12 | ☐ 11 | ☐ 21 | ☐ 22 | ☐ 23 | ☐ 24 | ☐ 25 | ☐ 26 | ☐ 27 | ☐ 28 |
| ☐ 48 | ☐ 47 | ☐ 46 | ☐ 45 | ☐ 44 | ☐ 43 | ☐ 42 | ☐ 41 | ☐ 31 | ☐ 32 | ☐ 33 | ☐ 34 | ☐ 35 | ☐ 36 | ☐ 37 | ☐ 38 |

## GENERAL

Has the patient been made aware of the level of investment that may be required? ☐ Yes ☐ No

**Please be assured that we will neither approach nor accept your patient for non-referred treatment.**

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