Endodontic Referral Form

- ***Patient Information***

Mr___ Mrs___ Miss___ Ms___

Surname_____Forename_____DOB_____

Address_____

_____

Tel (primary) _____Tel (other) _____

email_____

Tooth Requiring Treatment_____ Radiographs included? ___Yes ___No

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- ***Reason for Referral***

___Primary root canal treatment ___Re-treatment ___Diagnosis of pain ___Second Opinion

Is the tooth symptomatic? ___Yes ___No

Other *(please provide as much detail as possible)*

_____

_____

_____

_____

- ***Following endodontic treatment***

___Temporary restoration ___Permanent core *(at additional cost)*___Prepare post space *(at additional cost)*

Please not that no restoration will be carried out without the express permission of the referring general practitioner.

Other *(please state)*_____

_____

_____

____

Relevant medical history *(including medications)*_____

_____

_____

_____

- ***Referred by***

Name_____ Practice address_____

_____

_____Postcode_____

Signature_____Date_____

Once you have completed this form please submit it to Finest Smile Dental studio.
The contents of this form will be treated in strict confidence. Thank you

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