


endodontic referral



referring dentist

Name	_____	Date	_____
Address	_____	Tel	_____
	_____	Fax	_____
Postcode	_____	Email	_____

patient details

Name	_____	Home	_____
Address	_____	Work	_____
	_____	Mob	_____
Postcode	_____	DOB	_____

relevant medical history

Please include any radiographs which may help in evaluating the patient. We will return them to you after use.

type of referral (please tick)

- Patient new to your practice
 Regular attender

reason for referral (please tick)

- Consultation
 Initial Root Treatment
 Re-Root Treatment
 Post Removal
 Trauma
 Perforation/Root Resorption Treatment
 Instrument Removal
 Post & Core Build-Up
 Endodontic Surgery (consultation required)
 Other (please specify) _____

tooth notation

sedation required (oral / IV)

Yes No