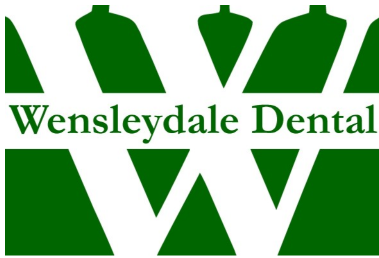


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# ENDODONTIC REFERRAL FORM

## Patient Information

| Name: | DOB: |
|---|---|
| Gender: | Tel Number: |
| Mobile: | E-Mail: |

Address:

Postcode:

Relevant MH:

## Reason for Referral

Referred for:

Tooth Notation:

Pulp Status: ☐ Vital ☐ Partially Vital ☐ Non-Vital

Pain Status: ☐ Present ☐ Absent

Appointment Required: ☐ Consultation Only ☐ Consultation & Treatment

Treatment Required: ☐ Primary Endo ☐ Non-Surgical Retreatment ☐ Surgical Treatment

Additional information: * Indicates does not attract additional fee

- ☐ Sclerosed canal*
- ☐ Complex root canal anatomy* e.g. significant root curvature
- ☐ Access though crown*
- ☐ Caries removal
- ☐ Crown removal
- ☐ Post & core removal
- ☐ Fabrication of temporary crown +/- temporary post
- ☐ Fractured instrument retrieval/ bypass
- ☐ Other (please specify):

## Referring Dentist

Summary:

1. I will restore the tooth on completion of the endodontic treatment and feel :
   a) The restorative prognosis is (please delete as appropriate): Very good/Good/Fair/Poor/Uncertain
   b) The periodontal prognosis is (please delete as appropriate): Very good/Good/Fair/Poor/Uncertain
2. I enclose a recent periapical radiograph.
3. I have discussed all of the above with the patient.

Signed: Date:

Print name in capitals:

Practice Name:

Address:

Postcode:

Tel Number:

E-mail: