Old Town Dental Practice

Private* Denplan*

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ENDODONTIC REFERRAL FORM

Patient Information

Name:	DOB:
Gender:	Tel no:
Mobile:	E-mail:
Address:	
Relevant MH:	

Reason for Referral

Referred for: Tooth notation:

Tooth: ☐ Incisor ☐ Premolar ☐ Molar ☐ Other, please specify:

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

Pain Status: ☐ Present ☐ Absent

Appointment Required: ☐ Consultation Only ☐ Consultation and Treatment

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

Additional Information: *indicating does not attract additional fee

- ☐ Sclerosed canal *
- ☐ Complex root canal anatomy * e.g. significant root curvature
- ☐ Access through crown *
- ☐ Caries removal
- ☐ Crown removal
- ☐ Post and 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 apropriate): Very good/Good/Fair/Poor/Uncertain

b) the periodontal prognosis is (please delete as apropriate) : 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:	
Tel no:	E-mail: