Endodontic
Referrals

Dr Sharon Stern – Endodontist
BDS (Rand), MClin (Guys), MRD, RCS (Ed), GDC 76799

Referring dentist

Name: ..... Date: .....

Address: ..... Tel: .....

..... Email: .....

Patient details

Name: ..... Tel: .....

Address: ..... DOB: .....

..... Email: .....

Treatment required

☐ Consultation ☐ Assessment for restorability

☐ Initial root canal treatment ☐ Apicoectomy/Root end surgery

☐ Root canal re-treatment ☐ Is the patient anxious?

Tooth/teeth: ..... Please include Radiograph: .....

Reason for referral: .....

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