Endodontic Referrals

Sharon Stern
Endodontist

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Referring Dentist Date: _____

Name: _____

Address: _____ Tel: _____

_____ E-mail: _____

_____

Patient Details

Name: _____ Tel: _____

Address: _____ D.O.B: _____

_____ E-mail: _____

_____

Treatment required (please mark with an x): ☐ Urgent ☐ Routine

☐ Consultation
☐ Initial root canal treatment
☐ Trauma
☐ Post removal
☐ Perforation
☐ Calcified canals
☐ Provision of a post and core or core only
☐ Is the patient anxious?

☐ Assessment for restorability
☐ Root canal retreatment
☐ Open apex/immature tooth
☐ Separated instrument
☐ Calcified canals
☐ Root end surgery/apicoectomy
☐ Provision of a temporary crown

Tooth/teeth:

Reason for referral:

_____

_____

_____