

Endodontic Referral Form

Practice Details

Referring Practice:

Referring Dentist:

Date Referred:

Patient Details

Patient's Name:

Patient's Address:

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Date of Birth:

Tel. No. Home:

Tel. No. Work:

Tel. No. Mobile:

Email:

Is this referral urgent? Yes No

Medical History

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Attempted treatment No treatment attempted

Pre-operative radiograph enclosed

Reason for Referral *(please tick all relevant boxes)*

Opinion only

Endodontic treatment

Difficult access

Difficult tooth morphology (curved canals)

Abutment for bridge/new crown

Existing post/post removal

Non-visible/sclerosed canals

Broken instrument

Other (please specify below)

Investigations

Has the patient been informed of the cost of the consultation/treatment? Yes No

Has the patient been informed of the location of the practice? Yes No



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