Referral Form

Introducing ______________________________

Referred by Dr. ______________________________

Appointment Date ____________________ Time ____________________

Forty-eight hours notice is greatly appreciated if you are unable to keep your appointment.

RIGHT	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	LEFT
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

HISTORY

- ❑ Toothache
- ❑ Pulp Exposure
- ❑ Apical Radiolucency
- ❑ Calcified Canals
- ❑ Separated Instrument
- ❑ Trauma/Fracture
- ❑ Perforation
- ❑ Previous R.C.T.

TREATMENT REQUIRED

- ❑ Root Canal Therapy Required
- ❑ Consultation and Treat as Required
- ❑ Retreatment
- ❑ Intentional R.C.T.
- ❑ Apicoectomy & Retrofill

FINALIZATION

- ❑ Post Space Preparation
- ❑ Core Build-Up (post as required)

Remarks ______________________________