

0121 382 8544

Endodontic Referral Form

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| Referring Dentist’s Details |
| **Name** |  |
| **Practice Name and Address** |  |
| **Mobile Telephone Number** |  |
| **Email Address** (please print clearly) |  |

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| Patient’s Details |
| **Name** |  |
| **Date of Birth** |  |
| **Address** |  |
| **Gender** |  |
| **Telephone Number** |  |
| **Work Telephone Number** |  |
| **Email Address** |  |

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| Referral Details |
| **Tooth/Teeth to be Treated** |  |
| **Type of Referral**(Check relevant box) |  | Consultation and Report Only |
|  | Primary Root Canal Treatment |
|  | Root Canal Re-Treatment |
| **Others Factors**(Check all relevant boxes) |  | Canal blockage |
|  | Difficult access |
|  | Post removal |
|  | Unable to locate all canals |
|  | Instrument removal |
|  | Trauma |
|  | Perforation or root resorption |
|  | Post and core build-up required |
|  | Definitive restoration required e.g. composite filling or build up, cuspal coverage onlay, crown |
| **Details** |  |
| **Please provide us with an up-to-date periapical radiograph of the tooth/teeth to be treated.** |

Signature of referring dentist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

GDC number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Be assured that we advise patients to continue seeing their own dental practitioner for their regular routine examinations and treatment.

We will only definitively restore the tooth/teeth being endodontically treated if you specifically request us to do so.