Dentist Referral Form

Referring Dentist's Details

Name: _____

Practice name & address _____

_____

Telephone number _____

Email address _____

Patient's details

Patient's name _____

Date of birth _____

Gender _____

Address _____

_____

Telephone numbers (home, mobile, work) _____

Email address _____

Referral Details

Tooth/ teeth to be treated: _____

Type of referral:

☐ Consultation only ☐ Initial root canal treatment ☐ Re-root canal treatment

Other factors:

☐ Canal blockage ☐ Unable to locate all canal ☐ Difficult access

☐ Post removal ☐ Instrument removal ☐ Trauma

☐ Perforation/ root resorption ☐ Post & 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 instruct patients to continue seeing their own general dental practitioner for their regular routine examinations and treatment. We will only definitively restore the tooth being endodontically treated (composite filling or build-up/onlay/ crown - as appropriate) if you request us to do so.