

Endodontic Referral Form

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Name of referring Dentist- _____

Practice phone number/mobile _____

Practice- E mail address _____

What tooth is to be treated ? _____

Patients' details- _____

Surname- _____

Forename- _____

Address- _____

Post code- _____

DOB - _____

Tel - _____

Email - _____

Relevant Medical History _____

Clinical details _____

1 Pain- _____ Y/N

2 swelling- _____ Y/N

3 Vital- _____ Y/N

4 peri apical lesion present- _____ Y/N

5 recent restoration- _____ Y/N

6 previous rct present- _____ Y/N

7 radiograph included- _____ Y/N

8 post space required - _____ Y/N

9 Temp restoration required IRM/GI/composite?