roseville house dental practice

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ENDODONTIC REFERRAL FORM

PATIENT DETAILS

Name: .....

Address: .....

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Postcode: .....

Date of birth: .....

Telephone (main): .....

Telephone (mobile): .....

Email: .....

Is this referral urgent? ☐ Yes ☐ No

REASON FOR REFERRAL (Please tick all relevant boxes)

- ☐ Opinion only
- ☐ Endodontic treatment
- ☐ Difficult access
- ☐ Difficult tooth morphology (curved canals)
- ☐ Other reason (please specify below)
- ☐ Abutment for bridge/new crown
- ☐ existing post/post removal
- ☐ Non-visible/sclerosed canals
- ☐ Broken instrument

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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

MEDICAL HISTORY

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- ☐ Attempted treatment
- ☐ No treatment attempted
- ☐ Pre-operative radiograph enclosed

REFERRING DENTIST DETAILS (Please ensure this section is fully completed)

Name: .....

Signed .....

Date: .....

Practice Address: .....

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Telephone No: .....

Email: .....