**Endodontic Referral Form**

Referring Dentist Details

|  |  |
| --- | --- |
| Name: |  |
| Practice Name: | Entre practice name here |
| Phone: | Enter practice phone number here |
| Email: | Enter practice email here |

Patient Information

|  |  |
| --- | --- |
| Full Name: | Enter patient full name here |
| Date of Birth: | Enter patient date of birth here |
| Phone: | Enter patient phone number here |
| Address: | Enter patient address here |
| City: | Enter patient city here |
| Postcode: | Enter patient postcode here |

Reason for Referral: (Please check all that apply)

Diagnosis and treatment planning

Root canal treatment

Retreatment of previous root canal

Apical surgery

Trauma

Pain management

Other: Click or tap here to enter text.

Referral details:

Click or tap here to enter text.

Radiographs:

Included

To be taken by endodontist

Emailed to: reception@kingsdentalspecialists.com

Brief Clinical History/Notes :

Enter brief clinical history / notes here

Any Medical Concerns or Allergies:

Enter any medical concerns or allergies here

Additional Information/Requests for Endodontist:

Enter additional information/request for endodontist here

Thank you for your referral

We will ensure that your patient receives the best care possible and will keep you updated on their treatment progress