**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