LHDP
REFERRAL CENTRE

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endodontic referral form

Practice Details

Referring Practice: Date Referred:

Referring Dentist:

Patient Details

☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Other Patient's Name:

Patient's Address

Telephone Numbers: Home: Work: Mobile:

Email:

Date of Birth: Is this referral urgent? ☐ Yes ☐ No

Reason for Referral (please cross all relevant boxes)

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

Brief History / Comments About This Referral

Investigations (already carried out)

☐ OPG ☐ PA's ☐ Other Radiographs ☐ Are these enclosed? ☐

Has the patient been informed of the cost of the consultation/treatment? ☐ Yes ☐ No

Has the patient been informed on the location of LHDP Referral Centre ☐ Yes ☐ No

Thank you for your valued referral