

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)

- | | |
|---------------------------------------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> Opinion only | <input type="checkbox"/> Surgical endodontics |
| <input type="checkbox"/> Endodontic treatment | <input type="checkbox"/> Existing post/post removal |
| <input type="checkbox"/> Difficult access | <input type="checkbox"/> Non-visible/sclerosed canals |
| <input type="checkbox"/> Difficult tooth morphology (curved canals) | <input type="checkbox"/> Pulp stones |
| <input type="checkbox"/> Abutment for bridge/new crown | <input type="checkbox"/> Broken instrument |
| <input type="checkbox"/> Other (please specify below) | |

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