



ENDODONTIC REFERRAL

Patient Name: _____

Phone: _____ Email: _____

Referring Dr: _____ Office: _____

- Please contact patient Patient was instructed to contact your office

REASON FOR REFERRAL:

- Carious pulp exposure
- Periapical pathosis
- Pain/Irreversible pulpitis
- Retreatment of previous RCT
- RCT required for restorative reasons

PLEASE CIRCLE TEETH INVOLVED:

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
R			A	B	C	D	E	F	G	H	I	J	L		
			T	S	R	Q	P	O	N	M	L	K			
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

AFTER ENDODONTIC REFERRAL:

- Temporary only
- Buildup for crown
- Permanent restoration on existing crown access
- Post and core build-up
- Leave post space of _____mm

ADDITIONAL COMMENTS:

Please email completed form, medical history, insurance info and x-rays to _____.