REFERRAL FORM

REFERRING PRACTITIONER

Name: | Tel: | Fax:

Practice: | Address:

PATIENT DETAILS

Title: (Mr/Mrs/Ms/Dr) | Name:

Address: | Postcode:

Tel (Home): | Work/Mobile: | Email:

Relevant Medical History: | Date of Birth:

REFERRAL DETAILS

Tooth/Teeth: | History:

Contact Patient:	☐	Patient to conatct us:	☐
Consultation/Opinion:	☐	Emergency:	☐
Primary Root Canal Treatment:	☐	Root Canal Re-Treatment:	☐
Trauma:	☐	Pain Diagnosis:	☐
Endodontic Surgery:	☐	Retain existing coronal restoration:	☐

Treatment to date:

Complications: Curvature: ☐ Calcification: ☐ Post: ☐ Crown: ☐
Previous RCT: ☐ Perforation: ☐ Fractured instrument: ☐

Additional Works Request: Caries Removal/Provisonal Restoration: ☐
Post space required: ☐ Preferred canal: _____
Fuji IX core: ☐ Restore tooth with provisional crown: ☐

Enclosures: Radiographs: No: ☐ Yes: PA ☐ BW ☐ DPT ☐

Signature: | Date:

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