ENDODONTIC REFERRAL FORM

Patient Name ________________________________ Referring Dentist ________________________________

Tooth # or Area __________________________________________

Status of the Tooth
☐ Symptomatic
☐ Asymptomatic
☐ Emergency treatment has been performed
☐ Previous endodontic treatment is failing
☐ Fractured tooth/restoration

Recent Treatment
☐ Restoration/temporary
☐ Crown/temporary
☐ Pulp cap
☐ Pulpotomy
☐ Periodontal Treatment

Endodontic Procedures Requested
☐ Evaluate and treat as necessary
☐ Evaluate only/consult Doctor before proceeding
☐ Non-surgical retreatment
☐ Surgical evaluation and treatment
☐ Prepare POST SPACE

Management, Medical, or Treatment Concerns: __________________________________________

____________________________
____________________________

Restorative Treatment Planned:
☐ Full coronal coverage
☐ Other ________________________________