**ENDODONTIST REFERRAL FORM**

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| **DATE OF REFERRAL** | Click here to enter a date. |

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| **PATIENT INFORMATION**  |
| **Patient’s Name** (First Name & Last Name)- Click here to enter text. | **Patient’s Phone Number:** [ ] Mobile [ ] Home [ ] WorkClick here to enter text. | **DOB:**Click here to enter text. |
| **Is patient a minor?** [ ] No [ ] Yes | **Name of minor patient’s parent or legal guardian-**Click here to enter text. |

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| **REFERRING DOCTOR/PRACTICE INFORMATION**  |
| **Name of referring doctor/practice-**Click here to enter text. | **Phone number of referring doctor/practice-**Click here to enter text. |
| **E-mail address of referring doctor/practice-** Click here to enter text. |
| **Mailing address of referring doctor/practice-**Click here to enter text.  |

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| **TOOTH/TEETH or ARE FOR ENDODOTNIC CONSIDERATION** |
|  | I | II | III |
| **Tooth or Area** | Choose an item. | Choose an item. | Choose an item. |

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| **STATUS** |
| [ ]  Asymptomatic | [ ]  Symptomatic | [ ]  Temperature | [ ]  Bite/chewing | [ ]  Exaggerated | [ ]  Lingering | [ ]  Vague | [ ]  Not localized |
| [ ]  Pulp exposed | [ ]  Deep caries | [ ]  Swelling | [ ]  PA lesion | [ ]  Perforation | [ ]  Pathologic resorption | [ ]  Obstruction (file/post/calcified) |
| [ ]  Immature root | [ ]  Previous RCT | [ ]  Post in root | [ ]  Crowned | [ ]  Discolored  | [ ]  Recent/Past history of trauma | Pain Scale: Choose an item. |

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| **REQUESTED ENDODONTIC SERVICES** |
|  | I | II | III |
| **Requested services** | Choose an item. | Choose an item. | Choose an item. |

**Additional Information:**

Click or tap here to enter text.

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| **IMMEDIATE POST-OP RESTORATION** |
| **How would you like us to restore the tooth after RCT is completed?** Choose an item. |

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| **PERMANENT RESTORATIVE PLAN** |
|  | I | II | III |
| **What is your restorative plan for this tooth?**  | Choose an item. | Choose an item. | Choose an item. |
| **COMMUNICATION REQUEST** |
| [ ]  Call before consult/treatment | [ ]  Call after consult | [ ]  Call before treatment | [ ]  Call after treatment | [ ]  Send post-op report |

**Additional Information:**

Click or tap here to enter text.

 Doctor’s Signature: