**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 Work  Click 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: