INTEGRATED ENDODONTIC SOLUTIONS

Referral Form to Endodontist (Root Canal Specialist)

124 Main Street, Suite #4, Huntington, NY 11743
Tel or Text: (631) 417-ENDO (3636)

Date of referral: ________________

Patient name: ____

Phone: ____

Referred by Dr. ____

Phone: ____

Tooth #: ____________ Appointment– Date __________ Time _________

Reason for Referral

- ☐ Consult only
- ☐ Endodontic treatment
- ☐ Endodontic retreatment
- ☐ Endodontic surgery
- ☐ CBCT imaging
- ☐ Post removal
- ☐ Dentialveolar trauma
- ☐ Endodontic emergency
- ☐ Complicated medical history
- ☐ Endodontic vs. implant evaluation
- ☐ Other: ____

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Pertinent History

- ☐ Previous RCT
- ☐ Pain and/or swelling
- ☐ PA lesion
- ☐ Pulp exposure
- ☐ RCT required for restoration

Treatment Performed

- ☐ Recent restoration
- ☐ RCT initiated
- ☐ Antibiotics prescribed
- ☐ Pain medication prescribed

Restorative Instructions

- ☐ Place temporary restoration
- ☐ Place build-up
- ☐ Place post & build-up
- ☐ Leave post space

Radiographs

- ☐ Sent by e-mail/mail
- ☐ Given to patient
- ☐ To be made

Comments: ____

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