RGV endodontics LLP

Endodontists

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Referral Form for Endodontic Evaluation and Treatment

Date: _____

Patient name: _____ DOB: _____

Tooth (Teeth) Number (s): _____

Patient Being Referred (Check all that Apply)

- ☐ Asymptomatic
- ☐ Pain
  - ☐ Spontaneous
  - ☐ Thermal
  - ☐ Biting
- ☐ Periapical Radiolucency
- ☐ Pulpal Exposure
  - ☐ Carious
  - ☐ Non- Carious
- ☐ Previous Pulpectomy
- ☐ Previous Root Canal Therapy
- ☐ Other

Endodontic Services Requested

- ☐ Non-Surgical Root Canal Treatment
- ☐ Non-Surgical Root Canal Retreatment
- ☐ Root-end Surgery
- ☐ Other

Upon Completion of Treatment Place:

- ☐ Temporary Filling
- ☐ Build-up
  - ☐ Resin
  - ☐ Amalgam
- ☐ Post
- ☐ Post Space Requested
- ☐ Other_____

Medication Given: _____

_____

Comments: _____

_____

Dr. _____ _____ _____

Print Name | Signature | Phone Number