PATIENT REFERRAL FORM

PATIENT INFORMATION

First Name: ____ Surname: ____

Telephone No: ____ Date of Birth: D D / M M / Y Y

Address: ____

REFERRING DENTIST

Name: ____ Telephone No: ____

Address: ____

Email: ____

INFORMATION

Tooth Numbers: ____

Requested Procedures:

Endodontic Evaluation ☐ Orthograde Endodontic Therapy ☐ Endodontic Microsurgery ☐

Patient Status:

Frequency of Discomfort:

None ☐ Occasional ☐ Constant ☐

Nature of Discomfort:

None ☐ Mild ☐ Moderate ☐ Severe ☐

Preferences:

Examination and Diagnosis Only ☐ Examination, Diagnosis and Treatment ☐

Have CBCT Scans been taken:

Yes ☐ No ☐

CBCT Scans:

Being Mailed ☐ Given to Patient ☐ None ☐ Emailed ☐

Radiographs:

Being Mailed ☐ Given to Patient ☐ None ☐ Emailed ☐

Comments: ____