



# GTA ENDODONTICS

DR. FARZAD DANESH DDS FRCD(C)

INTRODUCING: \_\_\_\_\_ PATIENT TEL: \_\_\_\_\_

## REASON FOR REFERRAL

CONSULT ONLY       CONSULT & TREATMENT       SECOND OPINION

- EMERGENCY
- INITIAL TREATMENT
- RE-TREATMENT
- RESORPTION
- ENDO TREATMENT STARTED – DATE: \_\_\_\_\_
- ENDO TREATMENT COMPLETED – DATE: \_\_\_\_\_
- TREATMENT PLANNING
- APICAL SURGERY
- TRAUMA
- cbCT SCAN

|          |   |   |   |   |   |   |   |   |  |   |   |   |   |   |   |   |   |  |
|----------|---|---|---|---|---|---|---|---|--|---|---|---|---|---|---|---|---|--|
|          | 8 | 7 | 6 | 5 | 4 | 3 | 2 | 1 |  | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |  |
| <b>R</b> |   |   |   | E | D | C | B | A |  | A | B | C | D | E |   |   |   |  |
|          |   |   |   | E | D | C | B | A |  | A | B | C | D | E |   |   |   |  |
|          | 8 | 7 | 6 | 5 | 4 | 3 | 2 | 1 |  | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |  |

**RADIOGRAPHS:**     ENCLOSED     NONE AVAILABLE     WILL SEND VIA E-MAIL

**CROWN/BRIDGE CEMENTED:**     TEMPORARILY     PERMANENTLY

**POST SPACE REQUIRED:**     YES     NO     PREFERRED CANAL: \_\_\_\_\_

**PLEASE CALL TO DISCUSS :**  YES     NO

REMARKS: \_\_\_\_\_

REFERRING DR. \_\_\_\_\_

TEL: \_\_\_\_\_

E-MAIL: \_\_\_\_\_

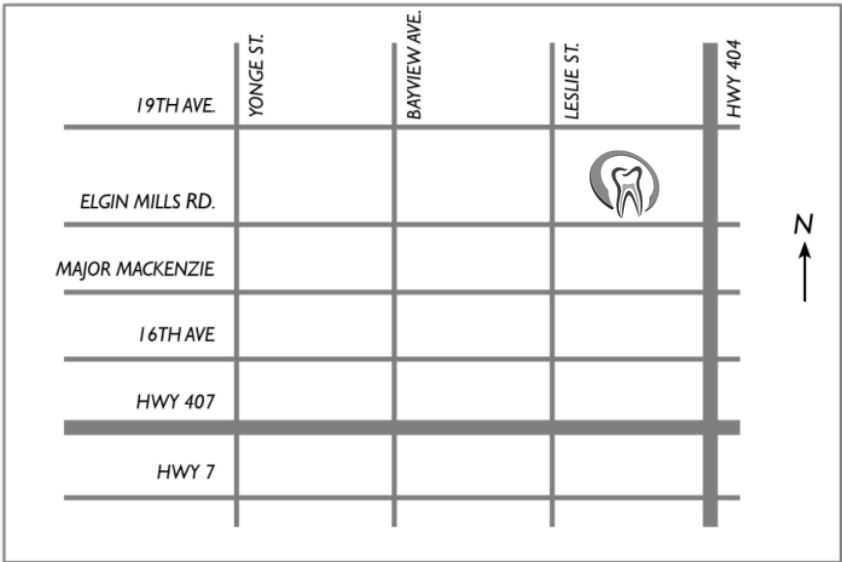
PLEASE INDICATE YOUR PREFERRED METHOD OF CONTACT



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