ENDO REFERRAL

GTA NORTH
PERIODONTICS & ENDODONTICS

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DATE: _____ PATIENT TEL: _____

INTRODUCING: _____

REASON FOR REFERRAL

- ☐ CONSULTATION
- ☐ ENDODONTIC INITIAL TREATMENT
- ☐ ENDODONTIC RE-TREATMENT OR APICAL SURGERY
- ☐ EMERGENCY PAIN RELIEF
- ☐ PLEASE CALL TO DISCUSS
- ☐ CBCT/ADVANCED IMAGING

8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8
8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8

TOOTH STATUS:

- ENDODONTIC TREATMENT INITIATED- DATE: _____
- CROWN/BRIDGE CEMENTED: ☐ TEMPORARILY ☐ PERMANENTLY
- POST SPACE REQUIRED: ☐ YES ☐ NO PREFERRED CANAL _____
- MEDICATION PRESCRIBED _____
- DATE AND TYPE OF RECENT DENTAL TREATMENT IN THE AREA _____

RADIOGRAPHS

☐ ENCLOSED ☐ WILL SEND VIA E-MAIL ☐ WITH PATIENT ☐ PLEASE TAKE

REMARKS: Please add a summary of your observation, restoration plan, and significant medical findings

_____

_____

REFERRING DR. _____

☐ TEL: _____ ☐ EMAIL: _____

PLEASE INDICATE YOUR PREFERRED METHOD OF CONTACT

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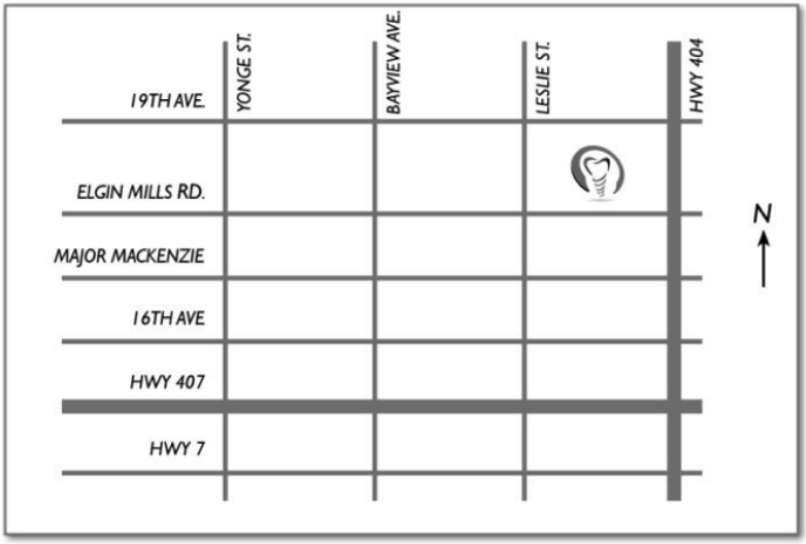

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