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Practice Limited to Endodontics
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Appointment Date: _____

PLEASE DO NOT TAKE ANY PAIN MEDICATION DAY OF APPOINTMENT

Introducing _____

Referring Doctor _____

Referring Doctor's Phone Number _____

TOOTH # _____

RIGHT LEFT

1	☐	2	☐	3	☐	4	☐	5	☐	6	☐	7	☐	8	☐	9	☐	10	☐	11	☐	12	☐	13	☐	14	☐	15	☐	16	☐
32	☐	31	☐	30	☐	29	☐	28	☐	27	☐	26	☐	25	☐	24	☐	23	☐	22	☐	21	☐	20	☐	19	☐	18	☐	17	☐

Please Evaluate ☐

Patient is Having Pain ☐

Endodontics Necessary for Restoration ☐

Vital pulp Exposure ☐

Tooth Has Been Opened for RCT on ☐

Prior Endodontic Treatment ☐

Place Core Buildup ☐

Place Post ☐

Temporize Only ☐

Prepare Post Space ☐

Crown Will Not Be Replaced ☐

Crown Will Be Replaced ☐

Apical Surgery ☐

Please Send More Referral Slips

Date of Referral: _____

SEND