academy dental care

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Endodontic Referral Form

REFERRING PRACTITIONER:

NAME: ______________________

ADDRESS: ______________________

______________________ POSTCODE: ______________________

TEL: ______________________ FAX: ______________________

MOBILE: ______________________ EMAIL: ______________________

PATIENT DETAILS:

DOES THE PATIENT HAVE PRIVATE HEALTH INSURANCE (PLEASE TICK) YES ☐ NO ☐

SURNAME: ______________________ FORENAMES: ______________________

TITLE: ______________________ DATE OF BIRTH: ______________________

ADDRESS: ______________________

______________________ POSTCODE: ______________________

TEL (HOME): ______________________ TEL (WORK): ______________________

MOBILE: ______________________ EMAIL: ______________________

ORAL HEALTH STATUS (PLEASE TICK):

ORAL HYGIENE: GOOD ☐ FAIR ☐ POOR ☐

SOFT TISSUE: NORMAL ☐ ABNORMAL ☐

REFERRAL REQUIREMENTS (PLEASE TICK):

☐ ENDODONTIC ASSESSMENT ☐ POST/FILE REMOVAL

☐ ROOT TREATMENT ☐ PLACEMENT OF CORE

☐ ROOT RETREATMENT ☐ OTHER

TEETH REQUIRING TREATMENT

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

ENCLOSURES (PLEASE TICK):

☐ PATIENT RECORDS ☐ X-RAYS ☐ OTHER

PATIENT MEDICAL HISTORY:

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COMMENTS:

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PRACTITIONERS SIGNATURE: ______________________ DATE: ______________________