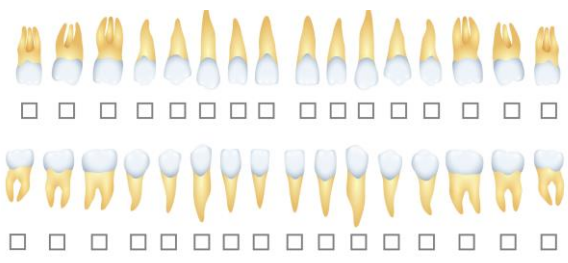
APEX ENDODONTICS

PATIENT REFERRAL FORM

Type or Referral:	Urgent □	Routine □	
REFERRING DENTIST DETAILS:			
Dentist Name			
Practice Address			
Phone			
Email			
PATIENT DETAILS:			
Name			
Address			
Phone		Post Code	
Email		Date of Birth	
CLINICAL DETAILS:			
Patient complaint			
Diagnosis			
X-rays	Included □	Not included □	
Additional comments			
Teeth of concern		□ Primary root canal □ Root canal retreatment □ Apicectomy □ Post and core □ Calcified canals □ Fractured instruments □ Complex anatomy □ Perforation repair □ Other (specify above)	
Signature		Date	

Provide all necessary treatment if diagnosed □
Ask before providing any other treatment □
Do not provide any other treatment apart from that specified in referral □