Mouth Matters Referral Practice: Endodontic Referral

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Practice Devoted to Endodontic Dentistry

Referring Dentist

Name ______________________ Date ______________
Address ______________________ Tel ______________
______________________ Fax ______________
__________ Post Code __________ Email ______________

Patient Details

Name ______________________ Home ______________
Address ______________________ Mob ______________
______________________ DOB ______________
__________ Post Code __________ Email ______________

Relevant Medical History

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PLEASE INCLUDE ANY RADIOGRAPHS WHICH MAY HELP IN EVALUATING THE PATIENT. WE WLLL RETURN THEM TO YOU AFTER USE.

Type of Referral (please tick)

- ☐ Patient new to your practice
- ☐ Regular Attender

Reason for Referral (please tick)

- ☐ Consultation
- ☐ Initial Root Treatment
- ☐ Re-Root Treatment
- ☐ Post Removal
- ☐ Trauma
- ☐ Perforation / Root Resorption Treatment
- ☐ Instrument Removal
- ☐ Post & Core Build-Up
- ☐ Endodontic Surgery (consultation required)
- ☐ Other (please specify) ______________________

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Tooth Notation

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Sedation Required (Oral / IV)

☐ Yes ☐ No

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Further Referral Forms can be downloaded from our website