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kataria

ENDODONTICS



www.katariaendodontics.co.uk

## Endodontic Referral Form

### **Patient Information:**

Mr  Mrs  Miss  Ms  Mx  Prof  Rev  Other

Surname: \_\_\_\_\_ Forename: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ Postcode: \_\_\_\_\_

Tel (primary): \_\_\_\_\_ Email: \_\_\_\_\_

**Tooth requiring treatment:** \_\_\_\_\_

### **Reason for Referral:**

Primary root canal treatment  Re-treatment  Diagnosis of pain  Second opinion

Is the tooth symptomatic?  Yes  No

Other (please specify in as much detail as possible):  
\_\_\_\_\_  
\_\_\_\_\_

Radiographs included?  Yes  No Periapical: \_\_\_\_\_ | \_\_\_\_\_

Bitewings:  Left  Right

### **Following Endodontic Treatment:**

Temporary restoration  Permanent core (at additional cost)  Prepare post space (at additional cost)

Please note that no restoration will be carried out without the express permission of the referring general practitioner.

**Other (please state):** \_\_\_\_\_

**Relevant Medical History (including medications):** \_\_\_\_\_  
\_\_\_\_\_

### **Referring Dentist:**

Name: \_\_\_\_\_ Practice address: \_\_\_\_\_

Postcode: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**By signing this form, you have confirmed you have the patient's permission to send their information on this referral**

Once you have completed this form, please submit it to one of the addresses below. The contents of this form will be treated in the strictest of confidence.



**Coulson**  
Ivory Dental  
28 Brighton Rd  
Coulson  
CR5 2BA  
Tel: 0208 668 2579



**Dorking**  
Surrey Dental Specialists  
Allen Court  
56A High Street  
Dorking  
Surrey RH4 1AY  
Tel: 01306 885898



**Wimbledon**  
Wimbledon Dental Wellness  
First Floor  
5-7 Wimbledon Bridge  
London  
SW19 7NH  
Tel: 020 8150 3737