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Endodontic Referral Form

Dr Mo Hattab (GDC 277340) | Simple to complex cases

For primary root canal treatment, retreatment and complex endodontic cases.

REFERRING DENTIST

Dentist name	GDC number	Date of referral

Practice name and address

Phone	Email

PATIENT

Title	Mr	Mrs	Miss	Ms	Dr	Other _____

Full name	Date of birth

Address

Home phone	Mobile phone	Email

Patient aware of and consents to referral	Yes	No

REFERRAL

Tooth / teeth of interest	Comments

Treatment requested	Primary RCT	Retreatment	Assessment	Other

Urgency	Routine	Urgent (pain or swelling)

Any swelling, discharge or sinus?	Yes	No	Has this happened previously?	Yes	No

Any tenderness to percussion?	Yes	No	Has this happened previously?	Yes	No

Is the patient taking analgesics?	Yes	No	Have they taken them previously?	Yes	No

Restorative prospects after treatment	Good	Average	Poor

Relevant medical history

Radiographs / CBCT enclosed	Yes	No

DECLARATION

Referring dentist signature	Date

SEND THIS REFERRAL TO US

Online refer.carestack.uk/?dn=darwindental&templateid=78
Email reception@darwindental.co.uk

Please attach radiographs, photos or scans.
We'll contact your patient within three working days.