WOKING
DENTAL CARE

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Endodontic Referral Form

REFERRING PRACTITIONER:

NAME: _____

ADDRESS: _____

_____ POSTCODE: _____

TEL: _____ FAX: _____

MOBILE: _____ EMAIL: _____

PATIENT DETAILS:

DOES THE P ATIENT HAVE PRIV ATE 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 ☐ F AIR ☐ POOR ☐

SOFT TISSUE: NORMAL ☐ ABNORMAL ☐

REFERRAL REQUIREMENTS (PLEASE TICK) :

☐ ENDODONTIC ASSESSMENT
☐ ROOT TREATMENT
☐ ROOT RETREA TMENT
☐ POST/FILE REMO VAL
☐ PLACEMENT OF CORE
☐ 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:

_____

_____

_____

COMMENTS:

_____

_____

PRACTITIONERS SIGNA TURE: _____ DATE: _____