NORTHWEST ENDODONTICS

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• REFERRAL SLIP •

Patient _____ Date _____
Patient Phone _____
Referring Doctor _____ Phone _____

☐ Patient Will Call to Schedule
☐ Call Patient to Schedule

☐ **URGENT**

Tooth/Teeth/Area:

Check all that apply:

☐ Previous RCT
☐ RCT started
☐ Pulp exposure
☐ Periapical lesion
☐ Pain inconsistent/difficult to localize
☐ Possible root fracture/crack
☐ Recent restoration type/date _____
☐ Swelling
☐ Sinus tract (fistula)
☐ Resorption
☐ Temp crown
☐ Antibiotics Rx'd

Treatment requested:

☐ CBCT scan only (includes radiology report)
☐ Exam only
☐ Root canal as indicated
☐ Retreatment (including apico) as indicated
☐ Other _____

Restoration requested:

☐ Temp filling
☐ Core build-up
☐ Restore access through crown
☐ Leave post space
☐ Post and core

Your restorative plans:

☐ Post/Core ☐ Crown/Bridge ☐ Filling ☐ N/A

History/Comments/Special instructions:

_____

_____

☐ Patient interested in oral sedation or nitrous
☐ Premed needed

See reverse for map