NORTHWEST ENDODONTICS

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IN THE ALOHA MEDICAL DENTAL SQUARE

• REFERRAL SLIP •

Patient _____ Date_____

Phone _____ Date of Birth _____

Referring Doctor _____

Referring Doctor Phone _____

☐ Patient Will Call to Schedule ☐ Urgent

☐ Call Patient to Schedule ☐ Non-urgent

Tooth/Teeth/Area _____

☐ CBCT Scan

☐ Exam and Consultation Only

☐ Exam and Treatment as Indicated

☐ Please Treat for Prosthodontic Needs

☐ Endodontic Treatment Initiated Date_____

☐ Previous Root Canal Treatment How long ago? _____

Restorative Plans _____

Leave Post Space? ☐ Yes ☐ No ☐ As needed

Restore Access Through Crown? ☐ Yes (Composite or Amalgam) ☐ No

History/Comments/Special Instructions/Special Patient Needs

_____

_____

_____

_____

_____

Premed ☐ Yes ☐ No