ENDODONTIC REFERRAL

PEMBROKE
DENTAL AND IMPLANT CENTRE

Patient Information

Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐

Surname: Forename: DOB:

Address:

Postcode:

Tel (primary): Tel (other): 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)

Referred by

Name: Practice address:

Postcode:

Signature: Date:

Radiography's included? ☐ Yes ☐ No ☐ Periapical

Bitewings: ☐ Left ☐ Right

Following endodontic treatment:

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

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

Other (please state):

Relevant Medical History (including medications):

Once you have completed this form please submit it to Pembroke Dental. The contents of this form will be treated in strict confidence

For administrative use only
Data received: Received by:
Action taken:

Clinician: Date: