NorthShore
DENTAL HEALTH

ENDODONTIC REFERRAL FORM

Date _____

Introducing _____

Patient Phone_____

Referring Dr. _____

*** No pain medication six hours before consultation**

R	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	L
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

Email xrays to: info@nsdhcenter.com

Remarks_____

_____

_____

TREATMENT REQUESTED:

☐ Diagnosis only ☐ Treatment

☐ Prepare post space

☐ Permanent restoration

Appointment Date:

Day_____ Date_____ Time_____

ENDODONTIC CONSIDERATIONS:

☐ Patient has pain to:

☐ cold ☐ heat ☐ pressure ☐ swelling

☐ Tooth has been previously openend

☐ X-ray revealed radiolucency

☐ Previous root canal ☐ Other

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