ORANMORE
ENDODONTICS

PATIENT REFERRAL FORM

PATIENT INFORMATION

First Name: Surname:

Telephone No: Date of Birth: D D M M Y Y

Address:

REFERRING DENTIST

Name: Telephone No:

Address:

Email:

INFORMATION

Tooth Numbers:

Requested Procedures:

Endodontic Evaluation ☐ Orthograde Endodontic Therapy ☐ Endodontic Microsurgery ☐

Patient Status:

Frequency of Discomfort:

None ☐ Occasional ☐ Constant ☐

Nature of Discomfort:

None ☐ Mild ☐ Moderate ☐ Severe ☐

Preferences:

Examination and Diagnosis Only ☐ Examination, Diagnosis and Treatment ☐

Select Canal/Canals:

Mesial ☐ Distal ☐ Palatal ☐ Mesio-Buccal ☐ Disto-Buccal ☐

Restoration Required:

Core ☐ Temporary ☐ Post Space ☐ Post & Build Up ☐

Radiographs:

Being Mailed ☐ Given to Patient ☐ None ☐ Emailed ☐

Comments: