



REFERRAL TO ENDODONTIST

Date:/...../.....

Dear:

Re: Dr / Mr / Mrs / Miss / Mst

Address:

Phone (Day time): Date of Birth:/...../.....

Tooth Number Has the tooth been accessed? Yes / No

Pulpal diagnosis upon access:

Clinical challenges encountered:

.....
.....

Restoration of tooth:

- Temporary Access Restoration
- Leave post space
- Core restoration

If patient elects to extract this tooth:

- Refer back to you for management
- Refer to:

Would you like your Report Emailed to you? Yes / No

If Yes - Email Address:

Referral by Dr: Signature:

Address:

Telephone Number:

RADIOGRAPHS ENCLOSED: Yes No (please tick)

(If possible please forward referral to our rooms prior to the appointment)

please note referrals can also be made online via our website



Disabled access is available - Please contact us prior to Appointment, if required.

Members of the Australian and New Zealand Academy of Endodontists