Referral Form for Endodontic Treatment

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DENTAL CARE

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Patient Details (please print clearly)

Name:.....

Address:.....

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Postcode:.....

Day time telephone number:.....

Mobile telephone number:.....

Date of birth: D D M M Y Y

Gender: ☐ male ☐ female

Referring Practitioner Details

Name:.....

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Practice:.....

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Address:.....

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Postcode:.....

Tel:.....

Email:.....

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Fax:.....

Dentist signature:

Date:.....

Referral Details

Referral for (please select):

Pain	yes / no
Swelling	yes / no
Urgent referral	yes / no

Clinical problems:.....

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Relevant medical history:.....

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Documents	Supplied	To be returned?
Patient records	Yes / No	Yes / No
Radiographs	Yes / No	Yes / No
Medical/dental history	Yes / No	Yes / No
Other (please specify)	Yes / No	Yes / No

Once a patient has been referred we will contact directly to arrange a consultation. Following the consultation, a full written report will be sent to you and your patient. During the treatment, patients are always reminded to continue to see their own general dental practitioner for regular routine examinations and necessary treatment.