Charing Cross Practice
Endodontic Treatment Referral Form

Date / /

Endodontic Referrals
Charing Cross Practice
Charing Cross
Norwich
NR2 4AX

Referring Colleague
Name_____
Address_____
_____

Patients Details
Name_____
Address_____
_____
Contact Tel. No_____Date of birth _____

Main Complaint / Reason For Referral
_____
_____
_____
_____
_____
Investigate & treat Opinion only

Relevant Medical History
_____
_____
_____
_____

We usually arrange appointments with the first available endodontist. If you would like your patient to see a specific dentist please let us know.

Clinical Details (please circle)

1) Problem tooth
8 7 6 5 4 3 2 1 | 1 2 3 4 5 6 7 8
8 7 6 5 4 3 2 1 | 1 2 3 4 5 6 7 8

2) Pain Yes No

3) Swelling Yes No

4) Vital Yes No

5) Periapical lesion Yes No

6) Post or core placement required Yes No

7) Recent restoration Yes No

8) Previous RCT None Self Other

9) Type of root filling G.P. Paste Ag # Inst

10) X-ray enclosed Yes No

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