Endodontic Referral Form

Charing Cross Practice

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Date of referral:

Referring Colleague

Name.....

Address.....

.....

Contact Tel. No.....E-mail:.....

Patients Details

Name.....Date of birth.....

Address.....

.....

Contact Tel. No.....E-mail:.....

Relevant medical history.....

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Clinical Details

Tooth being referred for:

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

Pain ☐ Swelling ☐ Periapical radiolucency ☐

Additional clinical information:

If you do not wish for us to place a definitive core in the tooth, please tick here: ☐

Radiograph enclosed (please tick): ☐