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Referred by Dr.______________________________

Office Phone Number ________________________

Comments: _____________________________

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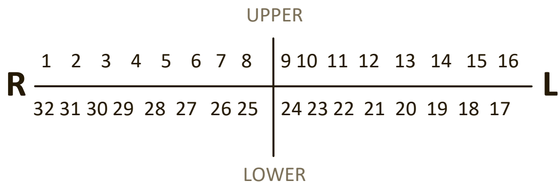
ENDODONTIC REFERRAL FORM

Introducing: ____ Date: _________________________

Patient's Phone #: _____________________________Appointment Date: _________________________

Tooth / Area in Question Is:



Additional Comments: _________________________

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Desired Treatment

- ☐ Evaluations Only
- ☐ RCT
- ☐ Retreatment
- ☐ Apicoectomy
- ☐ Post Space
- ☐ Cone Beam (3D Scan)
- ☐ Core Build Up

History

- ☐ Pain
- ☐ Swelling
- ☐ Bite Sensitivity
- ☐ Pulp Exposure
- ☐ Periapical Lesion
- ☐ Fracture / Crack
- ☐ Trauma
- ☐ RCT Initiated