RINGWAY ENDO - *DENTAL REFERRAL FORM*

FROM:

Practice Name: _____

Dentist Name: _____

Address: _____

_____

Telephone: _____ Mobile: _____

Email: _____

WE ARE REFERRING:

Patient: _____ Parent/ Guardian: _____

Date Of Birth: _____ (dd/mm/yy) Telephone: _____

Address: _____

_____

Telephone: _____ Mobile: _____

Email: _____

TOOTH/AREA TO BE TREATED (circle all that apply) :

18 17 16 15 14 13 12 11	21 22 23 24 25 26 27 28
48 47 46 45 44 43 42 41	31 32 33 34 35 36 37 38

REASON FOR REFERRAL (tick all that apply) :

- ❑ Consultation & Treatment Plan
- ❑ Root Canal Treatment Without Consultation
- ❑ Root Canal Treatment With Consultation
- ❑ Apicoectomy / Retrograde
- ❑ Remove Post
  - ❑ *Please Specify If RCT Needed*
- ❑ Leave Post Space

RADIOGRAPHS (tick appropriately) :

❑ Being Mailed ❑ Given To Patient ❑ None Sent

RELEVANT HISTORY:

(include any special factors – either dental or medical – such as allergies and specific medical problems relevant to diagnosis and treatment)

_____

_____

_____

_____

Ringway Endo offers a free follow up service for up to 1 year. We make sure that we always refer the patient back to your care after his endodontic treatment is completed. You will always receive a letter with a postoperative report and periapical X-ray along with the x-rays that you have sent us.