

ENDODONTIC REFERRAL



DR. TIM ADAMS, DMD
BOARD CERTIFIED ENDODONTIST
IV SEDATION AVAILABLE

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Patient Name: _____ Date: _____

Referring Doctor: _____ Phone: _____

Appointment Date and Time: _____

Reason for Referral:

- Endodontic consult and treat as necessary
- Endodontic retreatment/surgery
- Treat for restorative reasons (intentional endodontics)
- IV sedation (driver needed, NPO 8hrs before)

Tooth Number (please circle tooth):

PERMANENT TEETH															
UPPER RIGHT								UPPER LEFT							
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
LOWER RIGHT								LOWER LEFT							

Patient Exhibits (check all that apply):

- Toothache
- Pain and swelling
- Sinus tract
- Bite tenderness
- Pain of unknown origin

Restore Access With:

- Temporary
- Permanent restoration (composite core)
- Post space
- Post and core

Notes: _____

Please give 48 hours notice if you cannot make your appointment