

Patient Referral

APPOINTMENT

☐ Routine ☐ Priority ☐ Emergency

DATE _____

01 PATIENT

PATIENT NAME _____

DATE OF BIRTH _____

PHONE _____

EMAIL / INSURANCE _____

02 REFERRING OFFICE

REFERRING DOCTOR _____

PRACTICE _____

PHONE _____

EMAIL _____

03 TOOTH CHART

MARK TOOTH / TEETH TO BE TREATED

MAXILLARY

MANDIBULAR

R L

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

04 REASON FOR REFERRAL

SELECT ALL THAT APPLY

- | | | |
|---|---|--|
| ☐ Irreversible Pulpitis | ☐ Dental Trauma | ☐ CBCT Evaluation |
| ☐ Symptomatic Apical Periodontitis | ☐ Internal / External Resorption | ☐ Other _____ |
| ☐ Necrotic Pulp | ☐ Retreatment | |
| ☐ Cracked Tooth | ☐ Surgical Evaluation | |

05 REQUESTED TREATMENT

Evaluation

- ☐ Consultation Only
☐ Evaluate & Treat
☐ CBCT Imaging
☐ Second Opinion

Treatment

- ☐ Root Canal Therapy
☐ Retreatment
☐ Apicoectomy
☐ Apexification

Restorative

- ☐ Temporary Only
☐ Core Build-up
☐ Post Space
☐ Return to GP

Medication

- ☐ Premed Required
☐ On Antibiotics
☐ Blood Thinners
☐ Allergies

Additional

- ☐ Call Before Treating
☐ Sedation Requested
☐ X-rays Enclosed
☐ Email Report

06 CLINICAL NOTES

SYMPTOMS · HISTORY · MEDICAL ALERTS

REFERRING DOCTOR SIGNATURE _____

DATE _____