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Jake Garner
DENTISTRY

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Endodontic Referral Form

Referring dentist's Details

Name ______________________________
Practice ______________________________
Email ______________________________
Tel. ______________________________

Patient's Details

Title Mr/Mrs/Miss/Master
Name ______________________________ D.O.B. _____/_____/______
Address ______________________________
____
______________________________ Post Code ______________
Tel. ______________________________ Mobile ______________
Email ______________________________

Patient's medical history (Please include all medications and allergies)

____
____
____

Reason for referral

____
____
____
____

Has any treatment been provided?

____
____
____

Is the tooth part of a longer term restorative treatment plan?

____
____

How would you like the tooth restored?

- I will restore the tooth definitively please temporise the access ☐
- Please restore the tooth definitively ☐
- I will restore the tooth definitively but please provide a core ☐

Signature ______________________________

Please email any radiographs to address at the top where possible. If this is not possible please enclose.

Thank you for your referral.