J Hope

Endodontic Referrals

Patient details: (please use BLOCK CAPITALS)

Name: _____ Sex: ____ DOB:____/____/____

Address: _____

_____

Postcode: _____ Tel: _____ Mob: _____

Referral details:

Advice/ Second opinion only ☐ Primary Treatment ☐ Re-Treatment ☐ Post Removal ☐

Reason for referral (continue overleaf):

_____

_____

_____

Provisional diagnosis:

_____

Any other relevant information (including treatment already carried out):

_____

_____

Preferred final restoration/ core material:

Amalgam ☐ Composite ☐ Temporary material ☐

Referring GDP details:

Name: _____ Date: ____/____/____

Practice name: _____

Address: _____

_____

Checklist:

- You feel that the tooth will be predictably restorable following endodontic treatment
- Patient is aware of approximate private treatment charges including a £80 consultation fee
- At least one radiograph enclosed (if wet film this will be returned)
- Copy of recent medical history enclosed

addy dental care

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