DR. ASHOK REDDY

BDS, MFGDP (UK), MSc (ENDODONTICS)

ENDODONTIC REFERRAL FORM

REFERRING DENTIST			
NAME:		REFERRAL DATE:	
PRACTICE:			
ADDRESS:			
		TEL:	
POSTCODE:		E-MAIL:	

PATIENT INFORMATION			
NAME:		DOB:	
ADDRESS:		TEL (HOME):	
		TEL (MOBILE):	
POSTCODE:		E-MAIL:	

RELEVANT MEDICAL HISTORY
(Please send a copy of medical history forms if available)

TYPE OF REFERRAL

☐ REGULAR PATIENT TO YOUR PRACTICE
☐ NEW PATIENT TO YOUR PRACTICE

REASON FOR REFERRAL

☐ CONSULTATION ONLY
☐ INITIAL ROOT TREATMENT
☐ RE-ROOT TREATMENT
☐ POST REMOVAL
☐ TRAUMA
☐ PERFORATION/ROOT RESORPTION TREATMENT
☐ INSTRUMENT REMOVAL
☐ POST & CORE BUILD-UP
☐ ENDODONTIC SURGERY

HISTORY OF PRESENTING COMPLAINT
(Please specify offending tooth)

If we deem the tooth unsuitable for endodontic treatment because of poor prognosis, would you like us to discuss dental implants?
☐ YES ☐ NO