WATERCRESS DENTAL

Endodontics Referral Form

Practice Details

Referring Practice:.....

Referring Dentist:.....

Date Referred:.....

Patient Details

Patient's Name:.....

Patient's Address:.....

Date of Birth:.....

Tel. No. Home:.....

Tel. No. Work:.....

Tel. No. Mobile:.....

Email:.....

Is this referral urgent? Yes ☐ No ☐

Medical History.....

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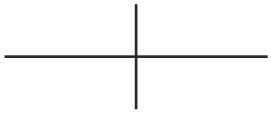
Attempted treatment ☐ No treatment attempted ☐

Pre-operative radiograph enclosed ☐

Reason for Referral (please tick all relevant boxes)

Tooth notation 

Investigation and endodontic treatment ☐

Re-treatment ☐

Root-end surgery ☐

Other (please specify below).....

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