Hurst Park Dental

Personal Care
Lasting Quality

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Endodontic Referral Form

Referring Dentist Practice Name and address:	

Date of Referral:	

Patient Name:	Mr Mrs Miss Ms Dr	DOB:
Address:		

Home Phone:	Mobile Phone	Email Address:

Tooth/ teeth of interest:		Comments:

At the moment of your referral:

Any swelling, discharge or sinus?	Yes ☐ ☐	Has this happened previously? ☐ Yes ☐ No
Any tenderness to percussion?	Yes ☐ ☐	Has this happened previously? ☐ Yes ☐ No
Is the patient taking analgesics?	previou Yes ☐ ☐ No	Have they taken them ☐ Yes ☐ No
What are the restorative prospects of the tooth after treatment?	Good ☐ Average ☐ Poor ☐	

Relevant Medical History:	