Barrowford Dental Practice
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Endodontic Referral

Patient Name:	DOB:
Patient Address:	Contact Telephone:

Relevant Medical History:
Provisional Diagnosis:
Pain History:
Previous Treatment:

Checklist:

- ☐ Preoperative Radiograph(s) taken. For multi-rooted teeth a second tube-shifted x-ray is advisable
- ☐ Patient information/Consent form discussed with and given to patient
- ☐ Restorability of the tooth has been determined including caries removal/re-walling where appropriate
- ☐ Patient has been informed of post-endo restoration options including full coverage restoration where appropriate
- ☐ Patient has been informed PR is a dentist with a special interest in endodontics but not a registered specialist

Referring Colleague and Address:	Date: