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COLUMBIA
ENDODONTIC GROUP, P.S.

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ENDODONTIC REFERRAL FORM

Patient's Name _____ D.O.B. _____ Date _____

Referred by Dr. _____ Pt's Contact Tel. #'s _____

☐ Consultation ☐ Treatment Tooth # _____

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

Please Circle Symptoms: **How long in pain?** _____

None
Cold Sensitive
Hot Sensitive
Swelling Present
Deep Decay
Chewing Pain
Constant Pain
Spontaneous Pain
Perio Concerns
Suspect Vertical Fracture

Pre-Med ☐ Latex Allergy ☐ Rx's Given: _____

History of Tooth:

Previous RCT	☐ Yes	☐ No	How long ago? _____
Recent Crown	☐ Yes	☐ No	How long ago? _____
Recent Filling	☐ Yes	☐ No	How long ago? _____
RCT Initiated	☐ Yes	☐ No	When? _____

Radiographs: ☐ Yes ☐ No

By E-mail:
dictation@columbiaendo.com ☐
appts@columbiaendo.com ☐

By Mail:
May keep ☐
Please return ☐

Complete Tx with:

☐ Composite
☐ Provide Post Space
☐ Amalgam
☐ I.R.M. **with** Cotton Pellet
☐ I.R.M. **without** Cotton Pellet

Is crown to be remade? ☐ Yes ☐ No

Comments: _____

_____ ☐ Call office before beginning treatment

PLEASE FAX OR MAIL TO US AT YOUR EARLIEST CONVENIENCE

White Copy - Patient (OVER)

Yellow Copy - Referring Office