



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 | Chewing Pain |
| Cold Sensitive | Constant Pain |
| Hot Sensitive | Spontaneous Pain |
| Swelling Present | Perio Concerns |
| Deep Decay | Suspect Vertical Fracture |

Pre-Med Latex Allergy Rx's Given: _____

History of Tooth:

- | | | | |
|----------------|------------------------------|-----------------------------|---------------------|
| Previous RCT | <input type="checkbox"/> Yes | <input type="checkbox"/> No | How long ago? _____ |
| Recent Crown | <input type="checkbox"/> Yes | <input type="checkbox"/> No | How long ago? _____ |
| Recent Filling | <input type="checkbox"/> Yes | <input type="checkbox"/> No | How long ago? _____ |
| RCT Initiated | <input type="checkbox"/> Yes | <input type="checkbox"/> No | When? _____ |

Radiographs:

Yes No

By E-mail:

dictation@columbiaendo.com
 appts@columbiaendo.com

By Mail:

May keep
 Please return

Complete Tx with:

- | | |
|--|---|
| <input type="checkbox"/> Provide Post Space | <input type="checkbox"/> Composite |
| <input type="checkbox"/> I.R.M. with Cotton Pellet | <input type="checkbox"/> Amalgam |
| | <input type="checkbox"/> 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