Dewsbury Dental Centre, 15 Halifax Road, Dewsbury,WF13 2JH 01924 465880

ENDODONTIC REFERRAL FORM

PATIENT DETAILS

Title/Name……………………………………………………………Date of birth…………………………….

Address……

………

Postcode…………………………………………………… Telephone………………………………………

REFERRAL DETAILS

Advice/2nd opinion ☐ Primary treatment ☐ Re-treatment ☐

Reason for referral and relevant information ………………………………………………………

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Provisional diagnosis…………………………………………………………………………………………………

Preferred core material

Amalgam ☐ Composite ☐ Temporary material ☐

CLINICIAN DETAILS

Name………

Practice name………………………………………………………………………………………………………

Address……

………

☐ Please tick to confirm the tooth is predictably restorable following endodontic treatment

☐ A radiograph has been provided (if using wet film this will be returned)

☐ The patient is aware of the private nature of this referral and has been informed of the estimated costs involved

☐ The patient has been made aware there is a mandatory £55 consultation fee

NOTE: In some cases, if the treatment is deemed to be too complex, you may be asked to re-refer the patient to a specialist endodontist