# WELLINGTON DENTAL PRACTICE

## ENDODONTIC REFERRAL

Wellington Dental Practice
47 High Street
Somerset
TA21 8QY

### PATIENT DETAILS

| | |
|---|---|
| Title | |
| Full Name | |
| Date of Birth | |
| Address | |
| Postcode | |

| | |
|---|---|
| Email Address | |
| Home Telephone | |
| Work Telephone | |
| Mobile Telephone | |

### IS THIS AN URGENT REFERRAL ☐ YES ☐ NO

### REASON FOR REFERRAL (PLEASE TICK ALL THAT APPLY)

- ☐ OPINION ONLY
- ☐ ENDODONTIC TREATMENT
- ☐ DIFFICULT ROOT MORPHOLOGY
- ☐ OTHER REASON / SYMPTOMS (PLEASE GIVE DETAILS BELOW)
- ☐ ABUTMENT FOR BRIDGE / CROWN
- ☐ EXISTING POST / POST REMOVAL / POST & CORE PLACEMENT
- ☐ NON VISIBLE / SCLEROSED CANALS
- ☐ BROKEN INSTRUMENT

### INVESTIGATIONS

Has the patient been informed of the cost of the consultation / treatment? ☐ YES ☐ NO

☐ ATTEMPTED TREATMENT ☐ NO TREATMENT ATTEMPTED ☐ PRE-OPERATIVE RADIOGRAPH ENCLOSED

### MEDICAL HISTORY (PLEASE PROVIDE / ATTACH DETAILS OF ANY MEDICAL CONDITIONS AND MEDICATION)

### REFERRING DENTIST DETAILS

| | |
|---|---|
| Dental Practice | |
| Dentist Name | |
| Address | |
| Postcode | |

| | |
|---|---|
| Telephone Number | |
| Email Address | |
| Signed | |
| Date | |

WELLINGTON DENTAL PRACTICE ESTD 2003