Endodontic Clinic Referral

enhance
endodontic clinic

GDP name: _____

Clinic name: _____ Postcode: _____

Contact tel: _____

Patient Details:

Date of birth: D D M M Y Y Y Y

Title: _____ Name: _____

Address: _____

_____

_____ Postcode: _____

Tel home: _____ Tel mobile: _____

Parent / Guardian name: _____

Initial Diagnosis / Reason for Referral (please tick)

- ☐ Endodontic assessment*
- ☐ Endodontic treatment*
- ☐ Urgent treatment for pain*

Treatment requested

- ☐ Root canal treatment only
- ☐ RCT + core/post
- ☐ RCT + core and crown

Further comments (e.g. curved canal, access problems): _____

_____

_____

Relevant medical history: _____

_____

_____

Relevant past dental history: _____

_____

_____

Would you like to discuss this referral informally on the phone? _____

Signed: _____ Date: _____

*Please inform the patient of relevant charges

Please send completed form to: Enhance, 68 St Mary's Street, Ely, Cambs, CB7 4HH
Email: referrals@enhance.myzen.co.uk