DISTRICT ENDODONTICS
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SPECIALIST MEMBER

Patient Name _____ Today's Date _____

Referred by Dr. _____ Office Phone _____

Tooth #_____ Appt Date/Time _____

REASON FOR REFERRAL:

- ❑ Consultation only
- ❑ Initial Endodontic Therapy
- ❑ Endodontic Retreatment
- ❑ Intentional Root Canal
- ❑ CBCT Scan
- ❑ Follow up Evaluation

PERTINENT INFORMATION (Please check all that apply):

- ❑ Restorability has been evaluated
- ❑ Antibiotics prescribed — If yes please describe: _____
- ❑ Pain medication prescribed — If yes please describe: _____
- ❑ History of trauma
- ❑ Pulp exposed
- ❑ Root canal initiated

RESTORATIVE INSTRUCTIONS (Please check all that apply):

- ❑ Preserve existing restoration
- ❑ Seal access with temporary filling
- ❑ Restore with core build up
- ❑ Leave post space

Comments: _____

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Dr. Signature_____ Date _____