KAVEH ZAND, DDS, MS
BOARD CERTIFIED ENDODONTIST

DISTRICT ENDODONTICS

ADVANCED ROOT CANAL SPECIALISTS

IDEEN MODARRES, DDS
AAE SPECIALIST MEMBER

www.districtendodontics.com

Patient Name _____ Referral Date _____

Referred by Dr. _____ Office Phone _____

Tooth# _____ Appt Date/Time _____

REASON FOR REFERRAL:

- ☐ Initial Endodontic Therapy
- ☐ Consultation
- ☐ Endodontic Retreatment
- ☐ Other: _____

PERTINENT INFORMATION (Please check all that apply):

- ☐ 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):

- ☐ Crown to be replaced
- ☐ Restore with build up
- ☐ Seal access with temporary filling
- ☐ Leave post space

COMMENTS/SPECIAL INSTRUCTIONS:

_____

_____

_____

Dr. Signature _____ Date _____

OFFICE LOCATIONS

WASHINGTON, DC
2021 K St NW, Suite 522
Washington, DC 20006

202.847.3288
202.847.3803
dc@districtendodontics. com

GAITHERSBURG, MD
610 Professional Dr, Suite 255
Gaithersburg, MD 20879

301.859.3636
301.859.0633
md@districtendodontics.com

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