



KAVEH ZAND, DDS, MS
BOARD CERTIFIED ENDODONTIST



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**
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