SHARROW VALE
DENTAL CARE

SPECIALIST ENDODONTIC REFERRAL FORM

CLINICIAN DETAILS

Clinician name
GDC number
Practice name
Address
Postcode
Contact Number(s)
Email (required)

PATIENT DETAILS

Title
First name
Surname
Date of Birth
Address
Postcode
Contact Number(s)
Email (required)

REFERRAL DETAILS

I would like to refer this patient for evaluation and / or treatment of (please check ALL teeth requiring assessment):

RIGHT

8 ○ 7 ○ 6 ○ 5 ○ 4 ○ 3 ○ 2 ○ 1 ○
8 ○ 7 ○ 6 ○ 5 ○ 4 ○ 3 ○ 2 ○ 1 ○

LEFT

1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○
1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○

Does the patient have pain / swelling?

○ None / Minimal ○ Moderate ○ Severe

Has an attempt at root canal negotiation already been made?

○ Yes ○ No

Is this a primary case?

○ Yes ○ No

Is this a root canal re-treatment case?

○ Yes ○ No

ADDITIONAL CLINICAL INFORMATION

Please forward relevant attachments.

I confirm that the above named patient has consented to onward referral for Specialist Endodontic Treatment and to being contacted by Sharrow Vale Dental Care.

Clinician signature _____

Date of referral _____

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