The ROOT CANAL Clinic

PATIENT REFERRAL FORM

Date: D D M M Y Y

PATIENT INFORMATION

Title: Mr [ ] Mrs [ ] Miss [ ] Ms [ ] Other [ ]

First Name: | Surname:

Address:

Telephone No: | Email:

Date of Birth: D D M M Y Y

Medical History:

REFERRING DENTIST

Name: | Telephone No:

Address: | Email:

Print Name: | Practice Stamp:

Signature:

Has patient been informed of costs: Yes [ ] No [ ]

REFERRAL INFORMATION

Tooth Requiring treatment:

Reason for Referral: Primary RCT [ ] ReRCT [ ] Diagnosis & Second Opinion [ ]

Radiographs Included: Yes [ ] No [ ] Symptomatic: Yes [ ] No [ ]

Other Information:

Planned Final Restoration/Treatment:

On completion RCT what would you like me to do: Temporise only & Send Back [ ] Place Definitive Core [ ]

Once ALL sections have been completed, please post the referral to Whitehouse Dental Clinic, 14 Coychurch Road, Pencoed, Bridgend CF35 5NG

Administration Section

Date Received: D D M M Y Y

Action Taken and by who: