Desert Dream Dentistry & Spa

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ENDODONTICS REFERRAL FORM

Please circle tooth or teeth for endodontic consideration:

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

	Endodontics Consultation
☐	Consultation only
☐	Pulp was exposed (vital / non-vital)
☐	Patient has (had) pain / swelling or sensitivity
☐	Radiolucency and / or pulpal involvement noted
☐	Evaluation for re-treatment
☐	Endodontics necessary for proper restoration
☐	Please evaluate & treat as necessary

Other finddings or remarks:_____

_____

_____

_____

☐ Analgesic Prescribed ☐ Antibiotic Prescribed ☐ CT Scan Completed

Patient Information:

Name:_____ DOB:_____

Phone:_____

Address:_____

Please Fax to: (760) 867-2333