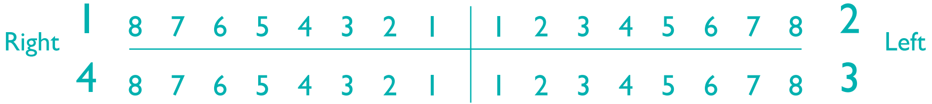
PATIENT'S NAME: ______________________ PHONE NUMBER: ______________

APPOINTMENT DATE: ___________________________ TIME: ______________




**HISTORY:**

- ❑ Patient has Discomfort/Pain
- ❑ Recent Dental Treatment __________ ______________________________
- ❑ Apical Radiolucency
- ❑ Swelling ❑ Fracture
- ❑ Pulp Exposure
- ❑ Traumatic Injury ______________
- ❑ Previous Root Canal Treatment
- ❑ How Long Ago ______________
- ❑ Allergies ______________

**TREATMENT ADMINISTERED PRIOR TO REFERRAL:**

- ❑ Occlusal Adjustment
- ❑ Endodontic Therapy has Been Initiated
- ❑ Incision & Drainage
- ❑ Premed Required
- ❑ Crown/Bridge is Cemented
  - ❑ Temporarily ❑ Permanently

Rx Antibiotic ______________________ ______________________________

- ❑ None

**TREATMENT TO BE COMPLETED AT WILLOWDALE ENDODONTICS:**

- ❑ Please Provide Consultation/Diagnosis
- ❑ Please Provide Root Canal Therapy
- ❑ Please Provide an Evaluation for Possible Endodontic Retreatment or Apical Surgery
- ❑ Please Leave a Post Space
- ❑ Please Consider Non-Vital Bleaching
- ❑ Sedation Required: ❑ Nitrous Oxide ❑ IV
- ❑ Oralmoderate

CBCT SCAN: ______________________

Reason: ______________________ ______________________________ ______________________________

QUAD: ______________________

Pan Ceph: ______________________

Referred by Dr. ______________________________ Date ______________

Email ______________________________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