ENDODONTIC REFERRAL FORM

This form has 2 pages to complete.

Practice Details

Referrer Name –	Date of Referral -
Practice Address – Post Code	Telephone – Email -

Type of Referral -	☐ Routine	Urgent

Patient Details

Name -	D.O.B -	Sex - ☐ Male Female

Patient Address – Post Code	Telephone – Email -

Please state which you would like -	☐	Diagnosis and Treatment Planning
	☐	Treatment

Please tick to confirm that primary dental decease has been undertaken.	☐	BPE scores			

Tooth of Concern:	Please tick to confirm the inclusion of a radiograph of good diagnostic value ☐

tel 01375 852044 fax 01375 856464 email info@elitedentalstudio.co.uk web www.elitedentalstudio.co.uk

Principal - Dr Shejal Patel BDS - GDC Number 84866
14 Civic Square Tilbury, Essex, RM18 8AD

Please provide a brief history of the problem being referred **AND** synopsis of recent intervention:

For which reason(s) is the tooth of importance?	
Mastication	☐
Appearance	☐
Occlusal Stability	☐
Strategic (e.g abutment)	☐

Please tick the following boxes to confirm that:	The tooth is restorable and has good periodontal support. ☐ The patient understands that if accepted for treatment, they must be available to attend EDS for several long appointments. The patient understands you will provide the coronal restoration following treatment. ☐

Medical History:

Patient Signature -

Referring Clinician Signature -

Please return this form via email to referral@elitedentalstudio.co.uk

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