



**DENTAL
HEALTH
ASSOCIATES**
ENDODONTICS

ENDODONTICS REFERRAL FORM

Referring Doctor _____ Date _____

Patient Name _____

Home _____ Work _____ Cell _____

Patient is Referred for

Exam and Consultation Only

Exam with Treatment

Previous Root Canal? Yes No

Nitrous Oxide? Yes No

Prepare Post Space? Yes No

	A	B	C	D	E	F	G	H	I	J					
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
	T	S	R	Q	P	O	N	M	L	K					

Double-click on the letter or tooth number, right-click and select "highlight text"

Post System (if preference): _____

Patient Dental Background

Is premedication needed? Yes No

Medical Concerns or Allergies? _____

Notes/Restorative Plan

Scheduling

Patient will call for appointment

Please contact patient to set up exam

Patient is scheduled – Appointment date: _____

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▶ [Click email link to send referral](#)

Clear Form



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