ROOT CANAL SPECIALISTS

9398 Viscount Blvd Ste. 4B
El Paso, TX 79925
915 595-1399
info@eprootcanals.com

REFERRAL FORM

Date: _____

Referring Doctor: _____ Referring Office: _____

Referring Office Email: _____ Office Number: _____

Patient Name: _____ Cell & Home: _____

Appointment Date: _____ Time: _____ AM / PM

Tooth #: _____

Right																Left
	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

Reason for Endodontic Referral

- ❑ Toothache/Swelling
- ❑ Pupl Exposure/Previous Pulptomy/RCT
- ❑ Endodontic Necessary for Proper Restoration
- ❑ Periapical Pathosis

Comments:

_____
_____
_____
_____
_____
_____

Following Endodontic treatment

- ❑ Cavit / IRM Temp Filling
- ❑ Prepare Post Space
- ❑ Core Build-up / Composite

Comments:

_____
_____
_____
_____
_____
_____