Dr. Najeeb Hussain

# ENDODONTIC REFERRAL FORM

Morden Smiles

**PRACTITIONER AND PRACTICE DETAILS:**

**Name of Practitioner**

**Practice Name**

**Address**

**Telephone**

**Email**

**PATIENT DETAILS:**

**Title** **DOB**

**Name**

**Address**

**Telephone**

**Email**

**MEDICAL HISTORY**

**TREATMENT REQUIRED (details):**

**REASON FOR REFERRAL:**

- ☐ **ROOT CANAL TREATMENT**
- ☐ **ROOT CANAL RE-TREATMENT**
- ☐ **INTERNAL BLEACHING**
- ☐ **OTHER (details):**

**URGENT?** ☐ **YES** ☐ **NO**

**PLEASE NOTE:**

**ONLY USE THIS REFERRAL FORM FOR PATIENTS AGED 16 OR OVER**

☐ **TREATMENT PLAN AGREED WITH PATIENT** ☐ **APPROPRIATE RADIOGRAPHS ENCLOSED**

**Signed by Dentist:**…… **Date:**……...

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