

Referring dentist:	
Practice address:	
Telephone:	
Date of referral:	
Patient Name/DOB:	
Patient Address:	
Patient Telephone (home/mobile):	
Tooth Notation:	87654321/12345678
	87654321/12345678

Status:	Yes:	No:
Diagnosis/Consultation only:	<input type="checkbox"/>	<input type="checkbox"/>
Acute symptoms: Pain / Swelling:	<input type="checkbox"/>	<input type="checkbox"/>
Pulp exposed and bleeding (temporary dressing placed):	<input type="checkbox"/>	<input type="checkbox"/>
Pulp exposed and necrotic material present:	<input type="checkbox"/>	<input type="checkbox"/>
Tooth open to drainage:	<input type="checkbox"/>	<input type="checkbox"/>
Endodontic treatment started & difficulties encountered:	<input type="checkbox"/>	<input type="checkbox"/>
Patient has vague symptoms - please assess:	<input type="checkbox"/>	<input type="checkbox"/>
Bridge/Crown cemented temp/permanent:	<input type="checkbox"/>	<input type="checkbox"/>
Elective Endo:	<input type="checkbox"/>	<input type="checkbox"/>
Re Root-treatment:	<input type="checkbox"/>	<input type="checkbox"/>
Radiographs Enclosed:	<input type="checkbox"/>	<input type="checkbox"/>

Further comments: