Okanagan Endodontic Specialists
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REFERRAL

Date: ___/___/___
Month Day Year

Referring Dr.: _____

Patient: _____ **Birth Date:** ___/___/___
Month Day Year

Address: _____

City _____ Postal Code _____ **Male or Female**

Phone: Res. _____ Bus. _____ Cell _____

Email: _____

Dental Plan:

	Prim. Ins.	Sec. Ins.
	Subscriber	Subscriber
	Gr#	Gr#
	ID#	ID#
	Birth Date	Birth Date

Has patient previously been seen by us? ☐ yes ☐ no

Teeth Needing Examination/Treatment

18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Special Consideration

- ☐ Patient requires premed antibiotic: _____
- ☐ Patient may require Anti-anxiety meds
- ☐ Prior difficulty with anesthesia

Referral Request

- ☐ Consult Only
- ☐ Consult and Treatment, as necessary
- ☐ Treat Irreversible/Necrotic pulp
- ☐ RCT initiated, please complete
- ☐ Retreatment or Surgery
- ☐ Other:

Existing Restoration

- ☐ Natural tooth
- ☐ Permanent Crown
- ☐ Permanent Crown temp cement, please remove
- ☐ Temporary
- ☐ Permanent Crown will be replaced

Requested Coronal Endo

- ☐ Temporary restoration
- ☐ Bonded core and composite
- ☐ Post space
- ☐ Other:

Urgency

- ☐ Patient in Pain
- ☐ Treat ASAP
- ☐ Schedule at convenience

Additional Information:

Signature: _____ Office Stamp:

☐ PLEASE CALL THE PATIENT ☐ PATIENT WILL CALL ☐ AN APPOINTMENT HAS BEEN MADE ☐ RADIOGRAPHS ENCLOSED