Print Form

East Alabama Endodontics

Root Canal Specialists

Jae I. Hwang, D.D.S. • Eric T. Ashley, D.D.S.

Date: _____ Referring Dentist: _____

To assist us with the care of your patient, please complete this entire referral form.

Patient Name: _____

Appointment Date: _____ Time: _____ A.M. / P.M.

ENDODONTIC CONSIDERATION FOR THE FOLLOWING:

TOOTH / TEETH: _____

PLEASE CHECK ALL THAT APPLY

REFERRAL REQUEST

◯ Evaluation ◯ Evaluation for Retreatment ◯ Endodontic Therapy ◯ Apicoectomy

POST TREATMENT RESTORATION TYPE

◯ Cavit ◯ Post space ◯ Post / Core build up ◯ Definitive Restoration

INDICATIONS FOR REFERRAL

◯ PARL on x-ray ◯ Necessary prior to restoration ◯ Pulpotomy completed ◯ Carious exposure

◯ Non-symptomatic ◯ Hot and Cold sensitive ◯ Palpation sensitive ◯ Percussion sensitive

◯ Bite sensitive ◯ Fistula present ◯ Recent TX (note below) ◯ Medication given (note below)

Additional Notes: _____

_____

_____

Referring Dentist Signature: _____

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