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🌐 TranscendEndo.com

PATIENT'S NAME: _____

DOB: _____ **PHONE:** _____ **TODAY'S DATE:** _____

APPOINTMENT DATE & TIME: _____

TOOTH NUMBER: _____ **REFERRING DOCTOR:** _____

REASON FOR REFERRAL TO ENDO:

- Temperature Sensitivity
- Pressure/Bite Pain
- Pulp Exposure
- Swelling
- Periapical Pathology
- Restorative Needs
- Cracked Tooth
- Resorption

RESTORATION OPTIONS:

- Permanent Restoration
- Post and Core
- Temporary Restoration *(please circle one below)*
 - Intraorifice Barrier YES (or) NO
 - Post Space Needed YES (or) NO

TREATMENT OPTIONS:

- Evaluate and Treat (or) Evaluate Only
- Root Canal Therapy
- Retreatment
- Apicoectomy

SPECIAL CONSIDERATIONS:

- High Anxiety
- Gagger
- Limited Opening
- Difficult Anesthesia
- Highly Calcified Tooth
- Medical Concerns
- Please send more Referral Pads!

ADDITIONAL COMMENTS: _____

We wanted to sincerely thank you and your patient for your trust in our office!