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HAMILTON COUNTY
 ENDODONTICS

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Practice Limited to Endodontics

Referring Dr.: _____ Patient Name: _____

Tooth Number: _____ Date Referred: _____

Appointment date & time: _____ Patient will call to schedule

- | | |
|---|--|
| <input type="checkbox"/> Pain | <input type="checkbox"/> Pt wants sedation |
| <input type="checkbox"/> Swelling | <input type="checkbox"/> Uncertain if pain is endodontic |
| <input type="checkbox"/> Asymptomatic | <input type="checkbox"/> Suspected cracked tooth |
| <input type="checkbox"/> Apical Radiolucency | <input type="checkbox"/> Questionable Restorability |
| <input type="checkbox"/> Pulp Exposure | <input type="checkbox"/> Resorption |
| <input type="checkbox"/> Root canal started/pulpotomy | <input type="checkbox"/> Previous Root Canal |
| <input type="checkbox"/> Endo necessary for restoration | <input type="checkbox"/> Virgin Tooth / Shallow Filling |

Rx Given: _____ Pre-Med Antibiotics

The following procedures are not routinely performed unless requested:

- Post space preparation Permanent restoration

If it is determined a tooth needs to be extracted:

Refer back to my office Refer to: _____

CBCT only (for non-endodontic purposes, referring Dr. will interpret)

Image region: _____

Comments: _____



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