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**

☐ Pain
☐ Swelling
☐ Asymptomatic
☐ Apical Radiolucency
☐ Pulp Exposure
☐ Root canal started/pulpotomy
☐ Endo necessary for restoration

☐ Pt wants sedation
☐ Uncertain if pain is endodontic
☐ Suspected cracked tooth
☐ Questionable Restorability
☐ Resorption
☐ Previous Root Canal
☐ 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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