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**

Status of the Tooth:

☐ Caries to the Pulp
❑ Hot/Cold Pain
☐ Biting Pain
❑ Swelling
☐ Apical Radiolucency
☐ Resorption
☐ History of Trauma
☐ Sinus Tract/Fistula
❑ Questionable Restorability
❑ Endo Necessary for Restoration
☐ Other: _____

Recent Treatment:

❑ Previous RCT
❑ Pulp Exposure
❑ New Filling/Crown
❑ RCT Started/Pulpotomy

❑ Rx Given: _____ ☐ Pre-Med Antibiotics: _____

Patient Requests: ❑ Oral Sedation ☐ Nitrous Oxide

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: _____

Comments: _____

_____

_____

_____

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