



# FALLSGROVE ENDODONTICS

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*Practice Limited to Endodontics*

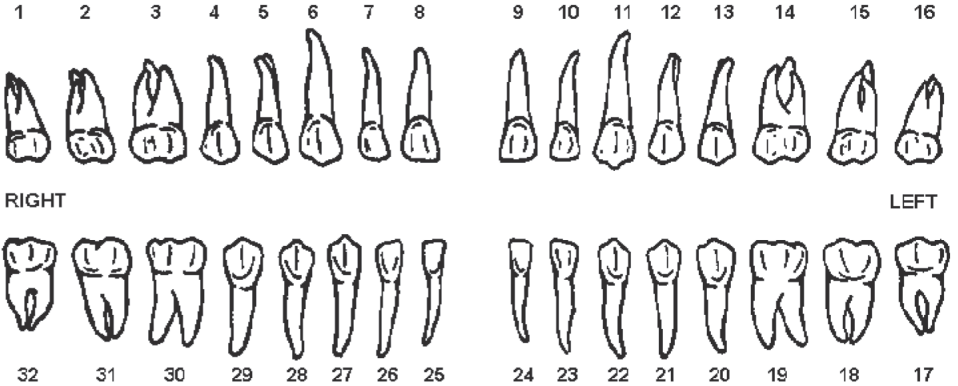
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Patient \_\_\_\_\_

Referred By \_\_\_\_\_ Date \_\_\_\_\_

- Consultation / Evaluation
- Patient has pain, swelling, or sensitivity
- Endodontics necessary for restoration
- Pulp exposure
- Tooth has been accessed / pulpotomy
- Radiolucency on radiograph
- Endodontic retreatment
- Endodontic surgery (Apicoectomy)



Post space desired?  Yes  No

Premedication required?  Yes  No

Remarks \_\_\_\_\_

\_\_\_\_\_

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Please check this box if you need more referral pads