❑ Kokomo ENDODONTICS

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(765) 455-2505 • Fax (765) 455-2564
1-800-932-6158
frontdesk@kokomoendo.com
www.kokomoendo.com

❑ HAMILTON COUNTY ENDODONTICS

14757 Oak Road, Suite 400 • Carmel, Indiana 46033
(317) 580-0123 • Fax (317) 580-0199
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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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