

AXXON ENDODONTICS



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ENDODONTIC REFERRAL FORM

REFERRING DOCTOR INFO:

DOCTOR NAME: _____ PRACTICE NAME: _____
PHONE: _____ EMAIL: _____
DATE OF REFERRAL: MM/DD/YYYY _____

PATIENT INFO:

PATIENT NAME: _____ INSURANCE / CARRIER ID: _____
PHONE: _____ EMAIL: _____
DATE OF BIRTH: MM/DD/YYYY _____

TOOTH / AREA OF CONCERN:

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1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
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32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

SYMPTOMS:

☐ PAIN TO COLD/HOT ☐ PAIN ON BITING ☐ SUSPECTED CRACK
☐ PULP EXPOSURE ☐ SWELLING ☐ SENSITIVITY

ANY PRIOR CARE:

☐ PULPOTOMY COMPLETED ☐ ACCESS OPENED ☐ TRAUMA HISTORY

REQUESTED SERVICE:

☐ CONSULTATION & EVALUATION ONLY ☐ EVALUATE AND TREAT AS NECESSARY
☐ INITIAL ROOT CANAL TREATMENT ☐ ROOT CANAL RETREATMENT
☐ APICOECTOMY / SURGICAL ENDODONTIC ☐ POST SPACE / CORE PLACEMENT
☐ CBCT

POST-TREATMENT RESTORATIVE PLAN:

☐ PLACE PERMANENT CORE BUILDUP ☐ PLACE TEMPORARY RESTORATION ONLY
☐ PREPARE POST SPACE ☐ INTERNAL BLEACHING

RADIOGRAPHS & NOTES:

☐ X-RAYS EMAILED ☐ X-RAYS SENT WITH PATIENT ☐ PLEASE TAKE NEW X-RAYS

CLINICAL COMMENTS:

REFERRING DOCTOR SIGNATURE:
