

**REFERRAL DATE:** \_\_\_\_\_

**APPOINTMENT:** Day \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

**INTRODUCING:** \_\_\_\_\_

**TEETH FOR ENDODONTIC CONSIDERATION**

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	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

- Please evaluate and treat if needed
- Patient has vague symptoms
- Pulp exposure
- Elective endodontics prior to restoration
- Periapical radiolucency
- Make post space
- Remove temporary crown

**Remarks:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Referring Doctor:** \_\_\_\_\_

*All patients will be advised to return to their referring dentist for final restoration*