# ENDODONTIC REFERRAL FORM

renew dental

## Patient Details

| | | | |
|---|---|---|---|
| First name(s) | | Referral date | |
| Surname | | Male ☐ | Female ☐ |
| Address | | | |
| Town | | Postcode | |
| Telephone | | Date of birth | |
| Email address | | | |

## Referring Practitioner

| | | | |
|---|---|---|---|
| Name | | GDP/GMC no. | |
| Practice | | | |
| Address | | | |
| Telephone | | | |
| Email address | | | |

## Medical/Social History

| Medical conditions |
|---|
| |

| List all medications being taken |
|---|
| |

| | | | | |
|---|---|---|---|---|
| Smoker | Yes ☐ | No ☐ | If yes, number smoked per day | |

## Referral Details

| Brief description of treatment required |
|---|
| |

| | | | | | |
|---|---|---|---|---|---|
| Radiographs | Periapical ☐ | Bitewing ☐ | OPG ☐ | CBCT ☐ | None ☐ |
| Reason if no periapical | | | | | |

Thank you for your referral