



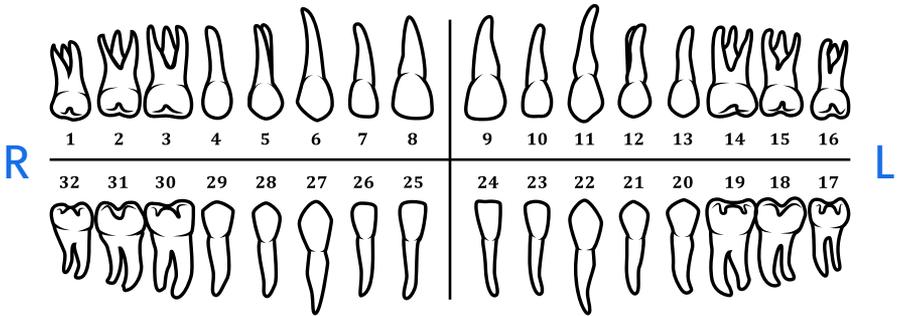
Referral Date _____

Introducing Patient _____

Appointment Date & Time _____

The patient is being referred for

- Evaluation & treatment Consultation 3D CBCT Imaging



Current Status

- Patient has/had pain or swelling Periapical radiolucency
 Pulp exposure Previous root canal therapy
 Root canal treatment initiated Suspecting cracked/fractured tooth
 Trauma date _____ RCT necessary for restorative

Upon treatment completion

- Temporize Prepare post space Restore as needed

Additional Comments _____

Referring Doctor _____ Phone # _____

- Please call me prior to starting treatment

Bring this referral slip to your appointment. Do not take pain medications prior to your appointment.

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