611 E. Bloomingdale Ave. STE C
Brandon, FL 33611
Phone: 813-820-0071
Fax: 813-820-0072
Email: info@mydentalday.com
Web: www.mydentalday.com

Endodontics Referral

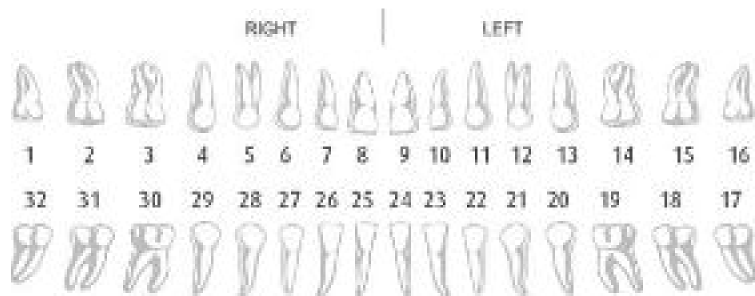
Patient Name: ________________________________ Date of birth: ________________________

Phone: ______________________ Parent's Name:______________________________________

Patient Insurance Information: ____

Reason for referral:

☐ Consultation
☐ Root Canal Treatment
☐ Root Canal Re-Treatment
☐ Apical Surgery
☐ Vital Pulp Therapy, Revascularization, or Apexification
☐ Other ______________________



Tooth number or area: ______________

Medical and Dental History:

☐ Negative
☐ Significant
☐ Patient may require nitrous oxide or oral sedation
☐ Special needs

Restorability and periodontal status:

☐ Tooth has been evaluated for restorability and periodontal support

☐ Crown lengthening may be needed after RCT

☐ Post space requested

☐ Patient is to return to referring dentist for all restorative and periodontal therapy

Notes:____

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Referring Doctor information:

☐ X-rays Given to Patient ☐ X-rays mailed/E-mailed ☐ Needs X-rays

Referring Doctor: ___________________________________ Phone: _________________________

Email address: _________________________ Date: ______________________________________