DENTAL SPECIALTIES
World Class Providers | Integrated Care | Exceptional Comfort
Northwest

ENDODONTIC REFERRAL

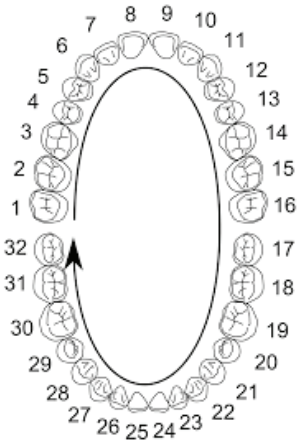
FROM: _____ **DATE**: _____

***PH**: _____

PATIENT: _____

AREA/ TOOTH OF CONCERN:

_____



HISTORY:

- ☐ Acute Symptoms
- ☐ Radiolucency
- ☐ Traumatic Injury
- ☐ Tx Complications
- ☐ Chronic Symptoms
- ☐ Pulp Exposure

_____

_____

_____

_____

RESTORATIVE TREATMENT PLAN: _____

_____

PROCEDURES REQUESTED:

- ☐ Evaluation Only
- ☐ Evaluations & Treat as Necessary
- ☐ Please send additional referral forms

FAXED:

Date _____

Initials _____

*If you received this FAX in error, please call immediately. Thank you.

701 5th Ave Suite 4660 Seattle, WA 98104 **206.682.8200**