TOOTHOPIA
Transformative experiences

Endodontic Referral Proforma

Patient Details

Title *(Mr/Mrs /Ms /Miss/Dr/Other)

Gender *(Female/Male/Non-binary/Other)

First Name *

Last Name *

Address Line 1 *

Address Line 2 *

Address Line 3

Address Line 4

Post Code *

Date of Birth *

Patient Email Address

Patient Telephone Number *

Patient Medical History *

Patient Dental History *

Referring Dentist Details

Dentist Title (Dr/Mr/Mrs/Ms/Miss/Other)

Dentist Name *

Dentist Address Line 1 *

Dentist Address Line 2 *

Address Line 3

Address Line 4

Dentist Post Code *

Dentist Email Address *

Dentist Telephone Number *

Treatment Required

Primary Endodontics ☐

Endodontics (including correction of iatrogenic errors) ☐

Consultation and Investigation (e.g. restorability assessment, fractures, etc.) ☐

Secondary (re-treatment endodontics) ☐

Is this an urgent case? * Yes / No

Referral Notes* (e.g. relevant medical history)

Do you have any files you wish to attach in support of this referral? (Radiographs / Clinical Photos)*
Please attach files together with this form in your referral email
(Accepted file types: jpg, gif, png, pdf.)

Once the endodontic treatment is completed, your patient will be advised to return to you for appropriate restoration of the tooth and continuing care.