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Referring Dr: Please email a copy of the referral slip to: info@forestlake-endo.com

Date _____

Introducing _____
for endodontic consideration.

R

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

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Referred by Dr. _____

Phone _____

Comments _____

Reason for Referral:

- Radiolucency
- Patient has had a previous RCT
- Pain is of undetermined origin
- Endodontic consultation ONLY
- CBCT
- Gentlewave
- RCT has been initiated; please complete treatment
- Swelling
- Other _____

Planned Restoration for this Tooth:

- Composite
- Post/crown
- Build-up/crown

Would you like us to:

- Create Post Space? Y N
- Fill Access with Composite? Y N