Rodney D. Ida, D.D.S., M.S., Inc.

Endodontic Referral Form

PATIENT NAME: ______________________________________

PATIENT PHONE: Home ( ) _____________ Cell ( ) _______________

REFERRED by DR: _____________________________________

TOOTH # / AREA: _____________________________________

SYMPTOMS

❒ Cold Pain

❒ Hot Pain

❒ Pressure Pain

❒ Swelling

❒ Severe Pain

❒ Moderate Pain

❒ Mild or No Pain

❒ Other: ____

HISTORY

❒ Toothache

❒ Pulp Exposure

❒ Apical Radiolucency

❒ Trauma / Fracture

❒ Crown When? _______________

❒ Previous Root Canal

❒ Trauma / Fracture

❒ Permanent Crown Cemented with Temp Cement

❒ Recent Restoration When? __________________

❒ Other: ____

TREATMENT REQUESTED

❒ Evaluate and Treat as Necessary

❒ Root Canal Treatment

❒ Retreatment

❒ Evaluate and Call Me

❒ Apical Surgery

❒ Other: ____

FINALIZATION

❒ Temporary Restoration

❒ Post Space Preparation

❒ Post & Core Buildup

❒ Permanent Access Restoration

Remarks: ____

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