FINGER LAKES
ENDODONTICS
OF ITHACA

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# PATIENT REFERRAL FORM

## Patient Information

Patient Name: _____

Date of Birth: _____

Phone: _____

Email: _____ ☐ Home ☐ Cell ☐ Work

## Reason for Referral

☐ Root Canal Evaluation
☐ Root Canal Therapy
☐ Retreatment
☐ Apicoectomy
☐ Pain
☐ Trauma
☐ Other: _____

## Tooth / Teeth Referred

☐ # _____ # _____ # _____ # _____
☐ Upper ☐ Lower ☐ Left ☐ Right

## Symptoms / Clinical Notes

☐ Pain ☐ Swelling
☐ Infection ☐ Abscess
☐ Other: ☐ Sensitivity

## ABX

☐ Yes
☐ No
Date of RX: _____
Name of ABX: _____

## Tooth TX Plan

☐ Crown
☐ Bridge Abutment
☐ Filling Only

### Tooth History:

_____
_____
_____

Referring Doctor Signature: _____

Date: _____

****Please send PA with all referrals****