



KINGSTON ENDODONTICS

Introducing _____ Date of Birth: ____/____/____

Referring Doctor: _____

Ref. Date: _____ Patient Phone: _____

673 Innovation Drive, Unit 7, Kingston, ON

Phone: (613)531-3500 Fax : (613)549-6500

Email: reception@kingstonendodontics.com

18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28
48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38

Referral Request

- ☐ Consultation and treat as needed
- ☐ Endodontic therapy needed for proper restoration
- ☐ Endodontic retreatment
- ☐ Endodontic surgery
- ☐ Post and core
- ☐ Root amputation

Dental/Oral Findings

- ☐ Pain/Swelling
- ☐ Pulp exposure
- ☐ Trauma/Crack
- ☐ Apical radiolucency
- ☐ Sinus tract
- ☐ Periodontal condition

Requested Coronal

Restoration

- ☐ Bonded resin core
- ☐ Post placement

Other

- ☐ Antibiotic prescribed
- ☐ Analgesics prescribed

Dental History

- ☐ Restoration
Filling _____ When _____
- ☐ Crown _____ When _____
- Prior endodontic treatment
When _____
- ☐ New crown to be made

Additional information / comments/ instructions

