Referral Form

Date of Referral: _____ Appointment Date: _____

Referring Doctor: _____ Office Number: _____

Patient Name: _____ Patient Number: _____

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

Reason for Endodontics Referral

- ☐ Endodontic consult for possible RCT
- ☐ Endodontic consult and RCT
- ☐ Endodontic consult for possible retreat or apicoectomy
- ☐ CBCT only
- ☐ Treatment not listed above, for example, internal bleaching, regenerative endo, etc.

Restorative plan preferred in Endodontic office

- ☐ Cavit and blue sponge, with a layer of resin liner
- ☐ Cavit and blue sponge, WITHOUT resin liner
- ☐ Prepare post space in the most suitable canal
- ☐ Core build up (without post)
- ☐ Core build up and post

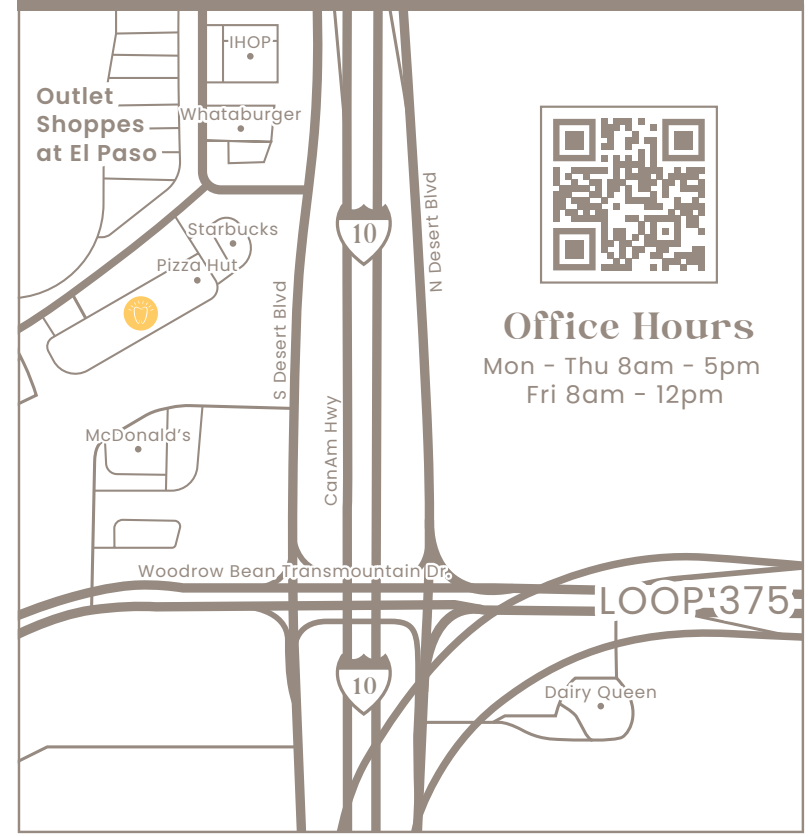
Remarks

_____

_____

Sun Endodontics

(915) 209-7575
915-229-8051
sunendodontics.com
info@sunendodontics.com
7049 S Desert Blvd, Ste 107 & 108,
El Paso, TX, 79835



Office Hours

Mon - Thu 8am - 5pm
Fri 8am - 12pm