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Patient Name:

Date of Referral:

Referring Doctor:

Appt. Date: _____

Appt. Time: _____

Tooth/Area to evaluate:

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

Requested Treatment:

Special Instructions:

- Evaluate Only
- CBCT Scan
- Root Canal Treatment
- Periapical Surgery
- Root Canal Retreatment

- Leave post space
- Sedation needed
- Remove post
- Antibiotics prescribed
- Core buildup

Clinical Findings:

Clinical History:

- Pulp exposure or trauma
- Infection or abscess
- Possible cracked tooth
- Failed previous RCT

- Y / N Tooth has temporary crown/bridge
- Y / N Tooth has permanent crown/bridge
- Y / N If "yes", age of crown/bridge _____

Notes: _____

Please send more referral slips

<p>LONGWOOD 2855 WEST S.R. 434 SUITE 1021 407-788-8880</p>	<p>MAITLAND 670 N. Orlando Ave. SUITE 203 407-755-4700</p>	<p>WATERFORD LAKES 12301 Lake Underhill Rd. SUITE 104 407-581-9515</p>	<p>KISSIMMEE 1956 East Osceola Pkwy. 407-581-9500</p>	<p>WINTER GARDEN 15815 Shaddock Dr. SUITE 140 407-554-1900</p>	<p>ORANGE CITY 2751 Enterprise Road SUITE 211 386-789-3636</p>
<p>DR. PHILLIPS 7932 W. Sand Lake Rd. SUITE 304 407-420-0009</p>	<p>MOUNT DORA 18660 US Highway 441 SUITE 104 352-729-4814</p>	<p>DAYTONA BEACH 1148 Pelican Bay Drive 386-256-2512</p>	<p>CLERMONT 2621 S US Highway 27 SUITE 101 689-304-2501</p>	<p>LAKE NONA 10007 WELLNESS WAY SUITE 130 407-704-7863</p>	

Please bring your ID and this referral slip with you to your appointment