



Patient Name: _____ Phone Number: _____

Referring Dentist: _____ Referral Date: _____

Scheduled Appointment Date: _____ Time: _____

Please circle teeth to be evaluated:

PERMANENT

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

Patient is being referred for the following:

- Consultation Only (please comment below) Evaluation & Root Canal Therapy
- Evaluation & Retreatment Evaluation for Endodontic Surgery

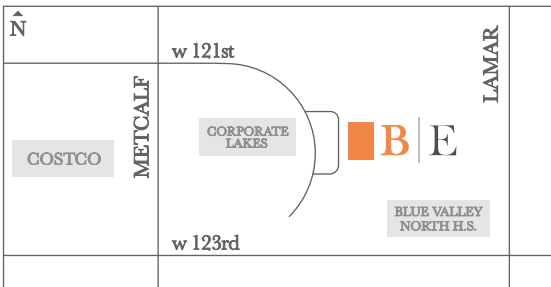
Patient presents with the following conditions:

- Diffuse Pain Caries Swelling Sinus Tract
- Periapical Lesion Trauma Pulpotomy/Pulpectomy completed
- Resorption Defect Suspected Cracked Tooth or Root Fracture
- Treatment could not be completed due to: _____

When treatment is complete:

- Place an appropriate access restoration Place a temporary restoration
- Place core build-up (a post will be placed if needed) Prepare a post space

Comments: _____



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If you are unable to keep this appointment,
kindly give 24 hours notice. Thank you.