# FRANKLIN ENDODONTICS

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Date:_____ Introducing:_____

Tooth #:_____ Referred by Dr._____

Patient Tel. #:_____ Doctor Tel. #:_____

| R | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | L |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 32 | 31 | 30 | 29 | 28 | 27 | 26 | 25 | 24 | 23 | 22 | 21 | 20 | 19 | 18 | 17 | |

## PURPOSE FOR REFERRAL

- ☐ Consultation
- ☐ Root Canal Retreatment
- ☐ Root Canal Therapy
- ☐ Apical Surgery
- ☐ CBCT
- ☐ Other:_____

## CURRENT CONCERNS OR FINDINGS

- ☐ Pain
- ☐ Abnormal Radiographic Findings
- ☐ Prior Root Canal Therapy
- ☐ Prior Apical Surgery
- ☐ Trauma
- ☐ Pulpal Exposure
- ☐ Swelling
- ☐ Other:_____

## PREFERRED RESTORATION

- ☐ Permanent Access Restoration/Core Buildup (Default if none selected)
- ☐ Temporary Restoration
- ☐ Post & Core
- ☐ Post Space

## IF NON - RESTORABLE

- ☐ Consultation Only
- ☐ Extraction
- ☐ Extraction with Bone Graft