COTTONWOOD ENDODONTICS,PC
EXCEPTIONAL ENDODONTIC CARE

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Patient Referral Form

Please complete and email to cottonwoodendo@hotmail.com with any x-rays, or call 801.278.3636.
For a patient in pain, please call. We make every effort to see them the same day.

REFERRING DOCTOR

Doctor name

Practice

Phone

Email

Date

PATIENT

Patient name

Date of birth

Phone

Dental insurance

Medical alerts / premedication

TOOTH AND URGENCY

Tooth number(s)

Urgency

- ☐ Routine
- ☐ Within a week
- ☐ Urgent: patient in pain

REASON FOR REFERRAL

- ☐ Evaluation and diagnosis
- ☐ Root canal treatment
- ☐ Retreatment
- ☐ Microsurgery / apicoectomy
- ☐ Cracked tooth evaluation
- ☐ Traumatic injury
- ☐ CBCT 3D scan
- ☐ TMD / jaw pain evaluation
- ☐ Other (see notes)

CLINICAL FINDINGS AND NOTES

Symptoms, tests, history and anything you would like us to know

ENCLOSED AND SCHEDULING

- ☐ X-rays attached
- ☐ CBCT attached
- ☐ Photos attached
- ☐ Please call the patient to schedule
- ☐ Patient will call your office

Referring doctor signature

Date

Thank you for your referral. After treatment you will receive a full report, and your patient returns to you for the final restoration.

specialist member