THE
HARLEY STREET
CENTRE FOR
ENDODONTICS

Referral Proforma

Date of Referral (dd/mm/yyy): _____

Referring Dental Surgeon _____

Address _____

_____

_____ Postcode _____

Phone _____ Fax _____

Email _____ Signature _____

We shall offer our first available appointment, unless you indicate a preference in this case for treatment to be carried out by one of us in particular. If the patient has been seen before, the same endodontist will usually provide treatment, unless it is an emergency appointment.

Patient Details

Title _____ First name _____

Surname _____ DOB (dd/mm/yyyy) _____

Address _____

_____

_____ Postcode _____

Tel/Home _____ Business _____ Mobile _____

Have we seen the patient before? Yes ☐ No ☐

Has the patient been informed of likely costs? Yes ☐ No ☐

Would your patient like us to contact them via email? Yes ☐ No ☐

If yes, email address _____

Patient Details

Tooth _____

Reasons for referral _____

_____

_____

_____

_____

Pain: Yes ☐ No ☐ If yes - Severe ☐ / Moderate ☐ / Mild ☐

Swelling: Yes ☐ No ☐

Tooth previously root treated: Yes ☐ No ☐

Consultation only ☐ Treatment ☐

Radiographs enclosed: Yes ☐ No ☐

Antibiotic cover required: Yes ☐ No ☐

Thank you for your referral

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Specialists in Endodontics