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Phone: 515-393-2556

PRAIRIE
— ENDODONTICS —

Fax: 515-346-6782
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ENDODONTIC REFERRAL FORM

Patient name: ______________________________ DOB: _______

Referring Dr. _________________ Pt's phone #: ______________

Date:_________ Tooth # __________

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

Treatment Requested:

☐ Consultation/Diagnosis ☐ Retreatment

☐ Root Canal ☐ Apicoectomy

Restorative Requests:

☐ Temporary ☐ Composite ☐ Post Space

Additional Considerations:

☐ Patient requests N2O/ oral conscious sedation

☐ Patient requires premedication

Comments: ____

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Please email or fax this form and send radiographs to:
email: info@desmoinesrootcanal.com mail: 1358 SE University Ave Waukee, IA 50263