

REFERRAL FORM

Introducing _____ Age _____ Sex _____

for endodontic consultation of the following tooth.

(teeth):

Right								Left							
01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

Comments..

When Endodontic Treatment is completed please:

- Place temporary restoration
- Restore simple access opening
- Prepare for post



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