Alchemy
DENTAL PRACTICE LTD transforming smiles

ENDODONTIC REFERRAL FORM

PATIENT DETAILS

Patients Title and Name	Age of patient in years	Sex	Date of Birth (DD/MM/YY)
Patient Address			
Mobile Telephone Number	Home Telephone Number	E-mail address	

REFERRAL INFORMATION

Referring Dentist Name	Referring Dental Practice
GDC Number of referring dentist	Date of decision to refer

RADIOGRAPHS

I can confirm diagnostically acceptable radiographs, clearly showing the apex of the roots have been sent with this referral ☐

Bitewings ☐ Periapical ☐ OPG ☐ None (reason required) ☐

Reason if no radiographs.....

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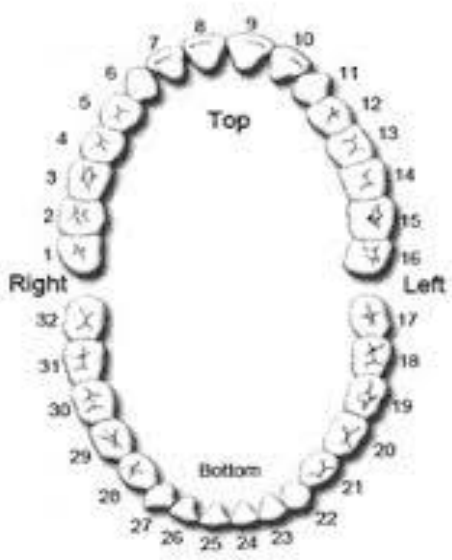
TREATMENT REQUESTED

Persistent signs/symptoms following RCT ☐ Complicated medical history eg restricted mouth opening ☐

Difficult root morphology eg curvature of canals ☐ Periradicular or apical surgery ☐

Fractures, cracks, root resorption, perforations ☐ Re-root treatment ☐

Other (please detail) ☐



Brief description of treatment required:

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ADDITIONAL INFORMATION	
Relevant medical information, ie medication including dosages, allergies etc	Is the patient a smoker? Yes ☐ No ☐
PATIENT CONSENT TO REFERRAL	
Has the patient understood and consented to the referral? Yes ☐ No ☐	
CONFIRMATION AND SIGNATURE OF REFERRING DENTAL PRACTITIONER	
Print Full Name..... Signature.....	Date.....

Please send all referrals to the following address:

Lauren Platt

Referral Centre
Alchemy Dental Practice
203 Edleston Road
Crewe
Cheshire
CW2 7HT

Telephone: 07848830091

Alternatively, referral forms can be emailed using the email address: lxp@alchemydental.co.uk

Appointments will be allocated dependent upon need and availability