**ENDODONTIC REFERRAL FORM**

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| --- | --- | --- | --- | --- | --- |
| **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........................................................................................................................................... | | | | | |
| **TREATMENT REQUESTED** | | | | | |
| Persistent signs/symptoms following RCT Complicated medical history eg restricted mouth opening    Difficult root morphology eg curvature of canals Peri radicular or apical surgery  ToothFractures, cracks, root resorption, perforations Re-root treatment  Other (please detail)  Brief description of treatment required:  ...........................................................................................  ..........................................................................................  .........................................................................................  .........................................................................................  .........................................................................................  ......................................................................................... | | | | | |
| **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 | | | Is the patient aware of the £95.00 assessment fee?    Yes No | | |
| **CONFIRMATION AND SIGNATURE OF REFERRING DENTAL PRACTITIONER** | | | | | |
| Print Full Name..............................................................................................  Signature...................................................................................................... | | | | Date.......................................... | |

Please send all referrals to the following address:

Site Lead

Referral Centre

Alchemy Dental Practice

203 Edleston Road

Crewe

Cheshire

CW2 7HT

Telephone: 01270211171

Alternatively, referral forms can be emailed using the email address: [info@alchemydental.co.uk](mailto:info@alchemydental.co.uk)

Appointments will be allocated dependent upon need and availability