



J Hope

Endodontic Referrals

Patient details: (please use BLOCK CAPITALS)

Name: _____ Sex: ____ DOB: ____/____/____

Address: _____

Postcode: _____ Tel: _____ Mob: _____

Referral details:

Advice/ Second opinion only Primary Treatment Re-Treatment Post Removal

Reason for referral (continue overleaf):

Provisional diagnosis:

Any other relevant information (including treatment already carried out):

Preferred final restoration/ core material:

Amalgam Composite Temporary material

Referring GDP details:

Name: _____ Date: ____/____/____

Practice name: _____

Address: _____

Checklist:

- You feel that the tooth will be predictably restorable following endodontic treatment
- Patient is aware of approximate private treatment charges including a £60 consultation fee
- At least one radiograph enclosed (if wet film this will be returned)
- Copy of recent medical history enclosed

Note: If the treatment is deemed to be too complex, a secondary referral to specialist Endodontist Peter Davis will be offered.



Addy Dental Care, Leypark Walk, Plymouth, PL6 8UE
Tel: 01752 781587
info@jhopereferrals.co.uk www.jhopereferrals.co.uk