LITCHFIELD ENDODONTICS
Quality at Your Service
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INTRODUCING:_____ DATE:_____

REFERRING DENTIST:_____

REMARKS:_____

_____

UPPER RIGHT UPPER LEFT

A B C D E F G H I J

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

T S R Q P O N M L K

LOWER RIGHT LOWER LEFT

REASON FOR REFERRAL:
- ☐NON-SURGICAL ROOT CANAL TREATMENT
- ☐RETREATMENT
- ☐EVALUATION FOR ENDODONTIC MICROSURGERY
- ☐DEEP CARIES/PULP EXPOSURE
- ☐CONSULTATION ONLY
- ☐NITROUS OXIDE/SEDATION MAY BE NEEDED

RESTORATIVE INSTRUCTIONS:
- ☐CORE BUILD-UP
- ☐POST SPACE
- ☐POST & CORE
- ☐TEMPORARY RESTORATION

MISCELLANEOUS INSTRUCTIONS:
- ☐PLEASE CONTACT ME ABOUT THIS CASE
- ☐PLEASE SEND MORE REFERRAL FORMS