SE Clinical (Manchester Clinic)
70 Ellesmere Road
Altrincham
Cheshire WA14 1JD

_____20____

Endodontic referral form

PATIENT DETAILS

Name _____ _____ Sex M/F

DOB ___ /___ /_____ (dd/mm/yyyy) email _____

Address _____

_____

Postcode _____ Tel No: Home _____ Work _____

Referral reason, (please include additional information e.g sclerosed canals, severely curved canals)

_____

_____

_____

_____

Referred for advice only? Y/N

Referred for advice & treatment? Y/N

History of present complaint

_____

_____

_____

Relevant Medical History/ inc. medications/allergies

_____

_____

Provisional Diagnosis

_____

Any treatment carried out already (**Please forward a current radiograph with this form**)

_____

_____

_____

_____

Signature _____ **Name (CAPS)** _____

Referring GDP details:

GDP address _____

GDP email _____

GDP tel no: _____