Lincoln Endodontics

7301 Plaza Court, Suite 101, Lincoln, NE 68516
Phone: 402-486-4380 | Email: info@lincolnendo.com

Endodontic Referral Form

Please complete and email to info@lincolnendo.com

REFERRING DOCTOR

Doctor Name

Practice Name

Phone

Email

PATIENT INFORMATION

Patient Name

Date of Birth

Phone

Email

REFERRAL DETAILS

Tooth Number(s)

Urgency

☐ Emergency ☐ Urgent (this week) ☐ Routine

Reason for Referral

☐ Root Canal Treatment ☐ Retreatment ☐ Apicoectomy / Surgery
☐ Trauma ☐ Cracked Tooth ☐ Pain Evaluation / Diagnosis

Other (specify)

CLINICAL INFORMATION

Symptoms / Chief Complaint

☐ Spontaneous pain ☐ Lingering pain (hot/cold) ☐ Pain on biting/percussion
☐ Swelling ☐ Sinus tract / fistula ☐ Asymptomatic

Cold Test

☐ No response ☐ Lingering ☐ Normal

Percussion Pain

☐ Yes ☐ No

Radiographic Findings

RESTORATIVE PLAN

Planned Restoration

☐ New Crown ☐ Endo Access Fill

Restore access opening at our office?

☐ Yes ☐ No

ADDITIONAL INFORMATION

Use this space for anything else we should know (attachments, history, special instructions, etc.)