

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 Lincoln Endodontics?

☐ Yes

☐ No

ADDITIONAL INFORMATION

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