

Please bring this referral to your appointment.

☐ **SACRAMENTO**

1810 Professional Dr., Ste. A
Sacramento, CA 95825
916-485-6900
fax 916-485-0102

☐ **ELK GROVE**

9309 Office Park Cir., Ste. 100
Elk Grove, CA 95758
916-423-3636
fax 916-683-2115

☐ **WOODLAND**

255 W. Court St., Ste. F
Woodland, CA 95695
530-669-7090
fax 530-669-7095

☐ **ROSEVILLE**

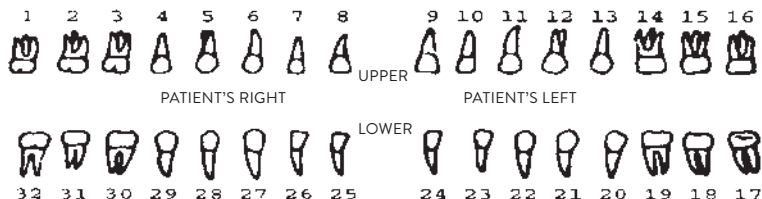
568 N. Sunrise Ave., Ste. 300
Roseville, CA 95661
916-626-3010
fax 916-783-1188

Appointment date: _____ **Time:** _____

Patient Name _____ Patient Phone _____

Referring Doctor _____

Please circle tooth or area to be evaluated



Referring Doctor's Comments and Clinical Information:

History

- ☐ Pain ☐ Pulp Exposure
☐ Apical Radiolucency ☐ Trauma
☐ Swelling ☐ Prior Root Canal
☐ Fracture ☐ Recent Filling
☐ Periodontal Condition ☐ Subgingival Caries

☐ **Restorability Concerns**

Treatment You Have Performed

- ☐ Occlusion adjusted
☐ Sedative dressing placed
☐ Pulpectomy
☐ Incision/drainage
☐ Rx Antibiotic _____
☐ Rx Analgesic _____
☐ None

Treatment to be Performed in the Endodontic Office

- ☐ Consultation/diagnosis only ☐ Leave post space
☐ Root canal treatment ☐ Permanent restoration in access opening

Referring Doctor Signature

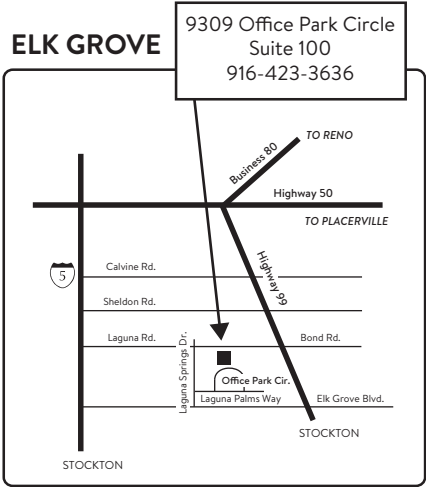
Dr. Signature _____ Date _____

— MAPS NOT TO SCALE —

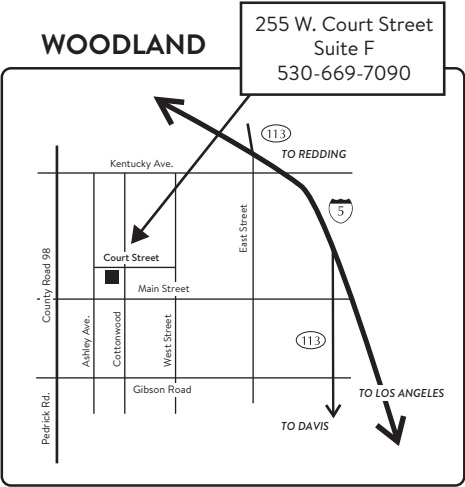
SACRAMENTO



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