

Patient's name	Title		
DOB	Gender	Male	Female
Email*	Landline		
Address	Mobile*		

## Relevant MH

<b>Tooth</b>	Incisor	Premolar	Molar	Other (specify tooth/area)
<b>Pulp Status</b>	Vital	Partially vital	Non-vital	
<b>Pain Status</b>	Present	Absent		

## Appointment

Consultation Only (No treatment)	Consultation & Treatment (Same appointment)	Treatment Only (Previously agreed)
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## Treatment

Primary endodontic treatment	Non-surgical retreatment	Surgical treatment
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## Additional Information

Sclerosed canal\*\*    Complex root canal anatomy\*\* e.g. significant root curvature    Access through crown\*\*  
 Caries removal    Crown removal    Post & core removal    Fabrication of temporary crown +/- temporary post  
 Fractured instrument retrieval/bypass    Other (please specify)

## Summary

1. I will restore the tooth on completion of the endodontic treatment and feel:

a) The restorative prognosis is:	Very good	Good	Fair	Poor	Uncertain
b) The periodontal prognosis:	Very good	Good	Fair	Poor	Uncertain

## Areas Of Interest

UR8 UR7 UR6    UR5 UR4 UR3    UR2 UR1 UL1    UL2 UL3 UL4    UL5 UL6 UL7  
 UL8 LR8 LR7    LR6 LR5 LR4    LR3 LR2 LR1    LL1 LL2 LL3    LL4 LL5 LL6  
 LL7 LL8

- I enclose a recent periapical radiograph.
- I have discussed all of the above with the patient.

Signed \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_ Practice \_\_\_\_\_

\*Preferred method of contact. \*\*Indicates does not attract additional fee.