# KC Endodontics

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# Dental Referral Form

Complete electronically or print and write clearly

## PATIENT INFORMATION

**Patient name**

**Date of birth**

**Phone**

## REFERRING OFFICE

**Referring doctor**

**Practice name**

**Office phone**

**Office fax**

## REFERRAL DETAILS

**Tooth or area**

**Preferred timing**

**REQUESTED SERVICE**

- ☐ Consultation / diagnosis
- ☐ Evaluate and treat as indicated
- ☐ Retreatment evaluation
- ☐ Surgical evaluation
- ☐ Dental trauma
- ☐ Other

**Clinical findings, symptoms, relevant history, restorative considerations, and records provided**

## FOLLOW-UP

- ☐ Send diagnostic / treatment report
- ☐ Please call to discuss this case
- ☐ Return patient for final restoration

**Referring signature**

**Date**

This form does not submit information online. Confirm a secure delivery method before sending patient records.

For urgent pain, swelling, or dental trauma, call the office rather than relying on the form alone.