

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 \_\_\_\_\_

Please state preferred method of contact