

REFERRAL TO DR V. WAGNER, ENDODONTIST:

FAX: 519-438-0066

REFERRAL FROM DR _____
(first and last names please)

PHONE: _____ CONTACT NAME: _____

INTRODUCING:

DR / MR / MRS / MISS / MS _____
first name surname

Telephone: h) _____ w) _____

c) _____ o) _____

Have we seen this patient before? Yes / No Patient's birthdate: _____
(month/day/year)

Patient's Address: _____

REFERRAL FOR: _____
(tooth or area)

Requesting: Consultation OR Consultation and treatment at first visit? (please circle one)
(if so, please send us a film and brief details of the situation)

Is this a retreatment? Yes / No Is there a pulp exposure? Yes / No

Has RCT already been started? Yes / No If yes, when? _____
Has a temporary filling been placed in the access? Yes / No

A film is being Mailed / Pt will bring / No film (please circle)

Patient has been put on: Antibiotics / Pain Meds / No Meds (please circle)

If meds RX'd, please list: _____

Discomfort? None Mild Moderate Severe (please circle all applicable)

Heat sensitivity Pressure sensitivity Cold sensitivity

Throbbing pain Facial Swelling Pain of unknown origin

Patient requires PROPHYLACTIC ANTIBIOTICS? Y / N

Patient has a Latex Allergy? Y / N

Additional Medical concerns / comments: _____

