core endodontics
Referral Form

Referring Dentist:
Dr. ___________________________
Phone: ________________________
Fax: __________________________
Email:________________________

Patient Information:

Name: _________________________
Phone: ________________________

Please Evaluate Tooth/Teeth:

18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28
48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38

Reason for Referral:
- ☐ Pain
  - ☐ Localized
  - ☐ Diffuse
- ☐ Clinical/radiographic pulp exposure
- ☐ Radiographic Pathology
- ☐ Swelling
- ☐ Fracture
- ☐ Trauma
- ☐ Discoloured Tooth
- ☐ Post Space Prep
- ☐ Other: _______________

Services Required:
- ☐ Consult Only
- ☐ Consult & Treatment
- ☐ Emergency Treatment
- ☐ Other: _______________

Tx History of Tooth:
- ☐ Access Only (date: _______)
- ☐ Previous RCT (date: _______)
- ☐ Crown/Bridge (date: _______)

301-459 George St N, Peterborough
Ph: 705.214.9646 Fax: 705.243.5365
info@coreendodontics.com
www.coreendodontics.com

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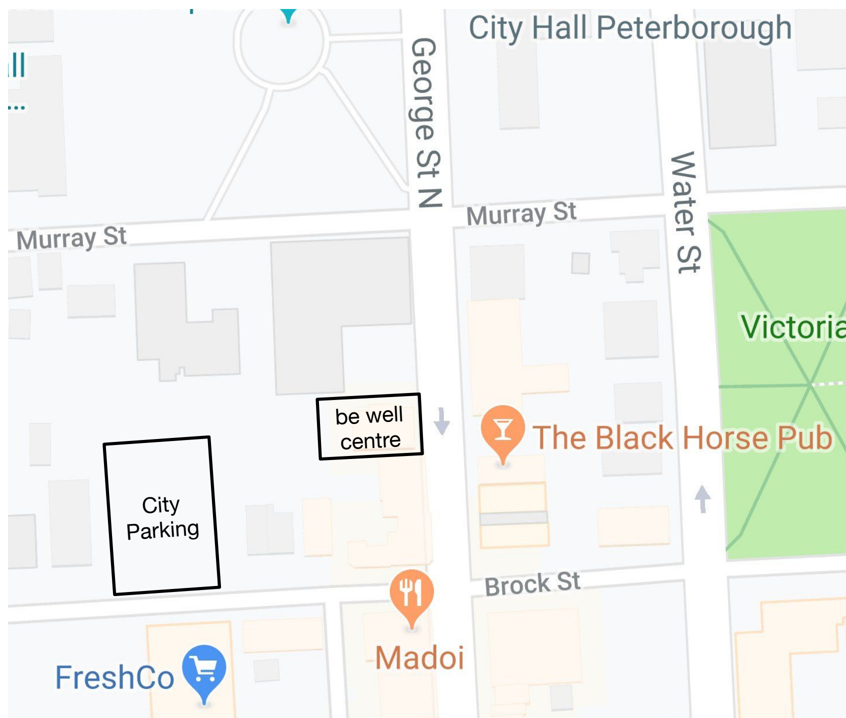
You have been referred to Dr. Arwa Siyam for specialized dental care.

Appointment Information:
Date: ________________ Time: ____________

☐ You will be called with an appointment time



Details:

✦ Please bring a list of your prescribed medications

✦ We are located on the 3rd floor (top floor) of the **be well centre**

✦ There is a separate elevator entrance to the right of the main doors

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