



# Luzmi Jutras DMD.MMSc.

Board Certified Endodontist  
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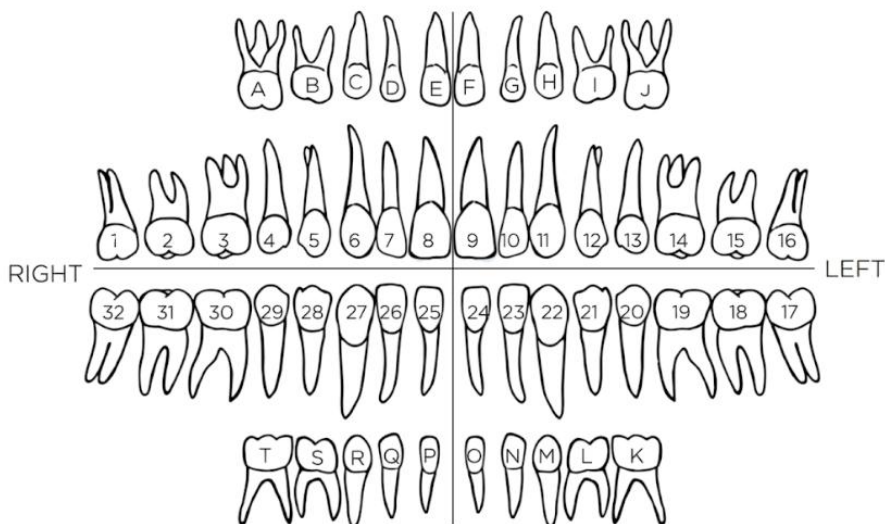
## PATIENT REFERRAL FORM

Date: \_\_\_\_\_ Patient Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Appointment date and time: \_\_\_\_\_

### Please Indicate Tooth to be Treated



### Reason for referral:

- Pain or swelling
- Radiographic findings
- Carious pulp exposure
- History of trauma
- Root canal needed for restoration
- Other: \_\_\_\_\_

### Requested Treatment:

- Consultation only
- Consultation & Treatment
- Root Canal Therapy
- Re-treatment
- Apical Surgery
- Cone beam CT scan
- Post space requested
- Please call to discuss
- Other: \_\_\_\_\_

### Comments:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Kindly referred by: \_\_\_\_\_

Office phone: \_\_\_\_\_ Email: \_\_\_\_\_