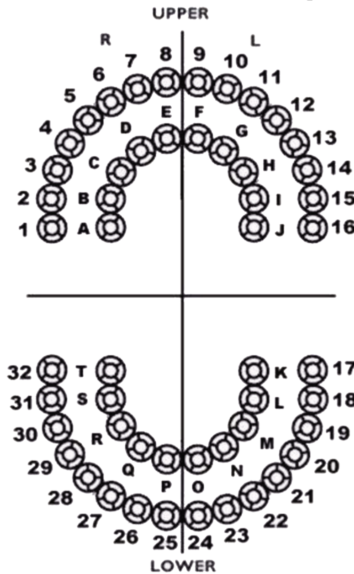
80 E. Belvidere Rd., Hainesville, IL 60030
Office: 847-986-6300 Fax: 847-986-6207
www.lakemoordental.com

Date:__________

Endodontic consideration needed for: ________________________
(patient name)



Remarks:____

____

Post Room Required? □Yes □No

□ Please evaluate

□ Patient has pain, swelling, or sensitivity

□ Endodontic therapy necessary for proper restoration

□ Pulp was exposed

□ X-Ray revealed a radiolucency

□ X-Rays supplied to: Hainesville@lakemoordental.com

□ Please Take All necessary X-Rays

A pre-operative consultation is required before a procedure can be performed.

Referring Dr.__________________________Phone #:____________________

Referring Office: ___________________________