Tower Hamlets NHS
Primary Care Trust

Specialist Endodontic Service Referral Form

Patients Name: **Patients Address: (*please check with patient if this is correct*)**	**Referring Practitioner Name:** **Referring Practitioner Address or stamp:**
Please circle the patients residential postcode: **E1, E2, E3 or E14** **Daytime telephone:** **Mobile:** **Home number:** **Email:** **Patient DOB:**	**Name of GP:** **Address of GP:**

Date of Referral:	
Signature of Referrer:	

Reason for referral (*tick as appropriate and provide details in the next section*)

- ☐ **Persistent signs and symptoms following root canal therapy**
- ☐ **Difficult root morphology, e.g. curvature of the Canals greater than 40º, non-negotiable canals**
- ☐ **Fractures, cracks, root resorption, perforations**
- ☐ **Complicating medical history e.g. restricted mouth opening**
- ☐ **Periradicular or apical surgery**
- ☐ **Re-treatment (complexicity 2 in Restorative Index of Treatment Need)**

NO REFERRAL WILL BE ACCEPTED UNLESS (Please tick to confirm):

- ☐ **Recent relevant radiographs must be enclosed (showing APEX OF ROOTS)**

Brief Medical and Dental history and endodontic procedure requested (please mention any current medication and or medical therapy.)

TOOTH NOTATION:

Any applicable patient charge must be taken by the referring practice.

Thank you for your referral, if accepted we will contact the patient and provide treatment as necessary and write to you afterwards. If however this form is incomplete we will only accept the referral once all the necessary information has been received.

Please complete this form and send back to:

WATERSIDE DENTAL HEALTH
1 RALEIGH HOUSE
ADMIRALS WAY
LONDON
E14 9SN

For any queries telephone 0844 375 6000 and select option 4

Provider Use Only	
Date referral received	
Checked to see if complete or further information needed	
Referral entered onto system	
Returned (inappropriate referral)	
Type of appointment required	
Date of treatment booked	
Patient Communication	