SCDC
Subang Central Dental Centre

# Patient Root Canal Treatment Referral Form

**Date:** _____

**Referral Clinic**:

**Patient Name:**

**Presenting complaint:** - Asymptomatic / Pain / Swelling / Draining Sinus; **Pain:** mild/ moderate/ severe

**Medical History:** ..... . ..... . ..... .....

**Dental History:** ..... . ..... ..... ..... . ..... ..... ..... . .....

**Treatment required: (Tooth *I* Teeth .....)**

| | | | |
|---|---|---|---|
| | Diagnosis and treatment plan only | | Manage Open apex closure |
| | Endodontic treatment *I* Retreatment | | Perforation repair with Bio Ceramics |
| | Endodontic surgery | | Trauma Management |

**Request for CBCT scan:** 4x4, 4x8, 8x10
*(Please circle your FOV)*

Others (Please Specify):

Remarks:

Clinic Stamp

Radiograph enclosed: PA *I* BW *I* OPG

Referred by Dr .... . ..... ..... . ..... ..... .... ..... ... ……..

Tel: ..... . .. ..... . . . .. . . .... . . ... ..... ..... .

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