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Date ____________________

Patient's Name ____________________

Referred by Dr. ____________________

Comments ____________________

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Please mark teeth to be treated:

Upper

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
R																	**L**
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

Lower

Reason for referral:

- ☐ Evaluation
- ☐ Root Canal Therapy
- ☐ Retreatment
- ☐ Post space
- ☐ CT Scan
- ☐ RCT started
- ☐ Pulp Exposure
- ☐ Apicoectomy