Henry M. Wright, Jr.
DDS, PA
PRACTICE LIMITED TO ENDODONTICS

REFERRAL INFORMATION

PATIENT NAME_____DATE_____

Referred by Dr._____Tooth #_____

STATUS

- ☐ **Asymptomatic**
- ☐ **Symptomatic**
- ☐ **Exposed Pulp**
- ☐ **Periapical Lesion**
- ☐ **Pulpotomy/Pulpectomy Performed**
- ☐ **Root Canal Tx. Attempted**
- ☐ **Previous RCT**

TREATMENT DESIRED

- ☐ **Evaluation Only**
- ☐ **Root Canal Treatment**
- ☐ **Retreatment**
- ☐ **Apicoectomy**
- ☐ **Post Space Preparation**

RESTORE ACCESS WITH

- ☐ **Temporary**
- ☐ **Composite**

Comments_____

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Appointment Scheduled for:

Date _____ Time _____

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