THE
HARLEY STREET
CENTRE FOR
ENDODONTICS

Referral Proforma

Date of Referral (dd/mm/yyy): _____

Referring Dental Surgeon _____

Address _____

_____

_____ Postcode _____

Phone _____ Fax _____

Email _____ Signature _____

We shall offer our first available appointment, unless you indicate a preference in this case for treatment to be carried out by one of us in particular. If the patient has been seen before, the same endodontist will usually provide treatment, unless it is an emergency appointment.

Patient Details Title _____ First name _____

Surname _____ DOB (dd/mm/yyyy) _____

Address _____

_____

_____ Postcode _____

Tel/Home _____ Business _____ Mobile _____

Have we seen the patient before? Yes ☐ No ☐

Has the patient been informed of likely costs? Yes ☐ No ☐

Would your patient like us to contact them via email? Yes ☐ No ☐

If yes, email address

Patient Details Tooth _____

Reason for referral _____

_____

_____

_____

_____

Pain: Yes ☐ No ☐ If yes- Severe ☐ /Moderate ☐ /Mild ☐ Swelling: Yes ☐ No ☐

Tooth previously root treated: Yes ☐ No ☐ Consultation only ☐ Treatment ☐

Radiographs enclosed: Yes ☐ No ☐ Antibiotic cover required: Yes ☐ No ☐

Thank you for your referral

121 Harley Street, London, W1G 6AX
Tel: 020 7935 6393 | Fax: 020 7935 6060 | Email:info@julianwebber.com | Web: www.rootreatmentuk.com
Mr Julian Webber BDS | MS | DGDP | FICD Trevor Lamb BDS | P Dip Dent | Dip Dent (SA) | FICD
Specialists in endodontics