Jen-Kuei Wang, PhD, DDS
Practice Limited to Endodontics

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Patient _____ DOB _____ Ph# _____

E-mail _____

Special Instructions:

_____

Tooth to be Evaluated

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

Reason For Referral
- ☐ Consultation only
- ☐ Periapical radiolucency present
- ☐ Pulp exposure
- ☐ RCT required for proper restoration
- ☐ Evaluation for endodontic surgery

Symptoms
- ☐ None ☐ Crack
- ☐ Cold ☐ Hot
- ☐ Biting ☐ Percussion
- ☐ Palpation ☐ Swelling

Radiographs
- ☐ PA. Date taken _____

Restorative Instructions
- ☐ Place Cavit • IRM • NE Temp in access cavity
- ☐ Leave post space
- ☐ Place permanent restoration

History of RCT on Referred Tooth
- ☐ No
- ☐ Yes. When? _____

Restorative Treatment Plan
- ☐ Build-up only
- ☐ Post & Core
- ☐ Crown

Referring Doctor:

_____

Signed _____

Date _____

For Your Information:

- Please bring this referral slip and any x-ray films if applicable.
- If you have dental insurance, please provide the documentation to assist claim processing.
- Written reports will be sent to your dentist at the start and end of treatment. When the treatment is completed, we will refer you back to your referring dentist.
- Please feel free to contact us if you have any questions.

Appointment Date _____ Time _____

Please give us a minimum of 48 hours notice if you will not be able to keep your appointment.