



Endodontists

Dr. Iván E. Rodríguez
Dr. Adalí Efraín Vélez
Dr. Ernesto G. Treviño

www.valleyendopractice.com

1610 E. Harrison Ave.
Suite A
Harlingen, TX 78550
(956) 412-9500
(956) 412-1146 fax

5421 S. McColl Rd.
Stoneridge Business Park
Edinburg, TX 78539
(956) 994-9500
(956) 686-4095 fax

Referral Form for Endodontic Evaluation and Treatment

Date: _____

Patient name: _____ DOB: _____

Tooth (Teeth) Number (s): _____

Patient Being Referred (Check all that Apply)

- | | |
|--|--|
| <input type="checkbox"/> Asymptomatic | <input type="checkbox"/> Pulpal Exposure |
| <input type="checkbox"/> Pain | <input type="checkbox"/> Carious |
| <input type="checkbox"/> Spontaneous | <input type="checkbox"/> Non- Carious |
| <input type="checkbox"/> Thermal | <input type="checkbox"/> Previous Pulpectomy |
| <input type="checkbox"/> Biting | <input type="checkbox"/> Previous Root Canal Therapy |
| <input type="checkbox"/> Periapical Radiolucency | <input type="checkbox"/> Other |

Endodontic Services Requested

Upon Completion of Treatment Place:

- | | |
|--|---|
| <input type="checkbox"/> Non-Surgical Root Canal Treatment | <input type="checkbox"/> Temporary Filling |
| <input type="checkbox"/> Non-Surgical Root Canal Retreatment | <input type="checkbox"/> Build-up |
| | <input type="checkbox"/> Resin |
| <input type="checkbox"/> Root-end Surgery | <input type="checkbox"/> Amalgam |
| <input type="checkbox"/> Other | <input type="checkbox"/> Post |
| | <input type="checkbox"/> Post Space Requested |
| | <input type="checkbox"/> Other _____ |

Medication Given: _____

Comments: _____

Dr. _____
Print Name Signature Phone Number