ENDODONTIC SPECIALISTS OF MADISON, S.C.

FREDERICK L. KATZ, D.D.S., M.S.D.
DIPLOMATE, AMERICAN BOARD OF ENDODONTICS

ENDODONTIC REFERRAL FORM (fax, mail or e-mail)

1. Referring Dr. _____
   Phone _____ Referral Date _____

2. Patient Name _____
   Has patient been to the office before? Yes _____ No _____
   Phone numbers: Home _____
   Work _____
   Cell/Pager _____
   DOB if minor ____/____/____

3. Pre-medicate? Yes _____ No _____

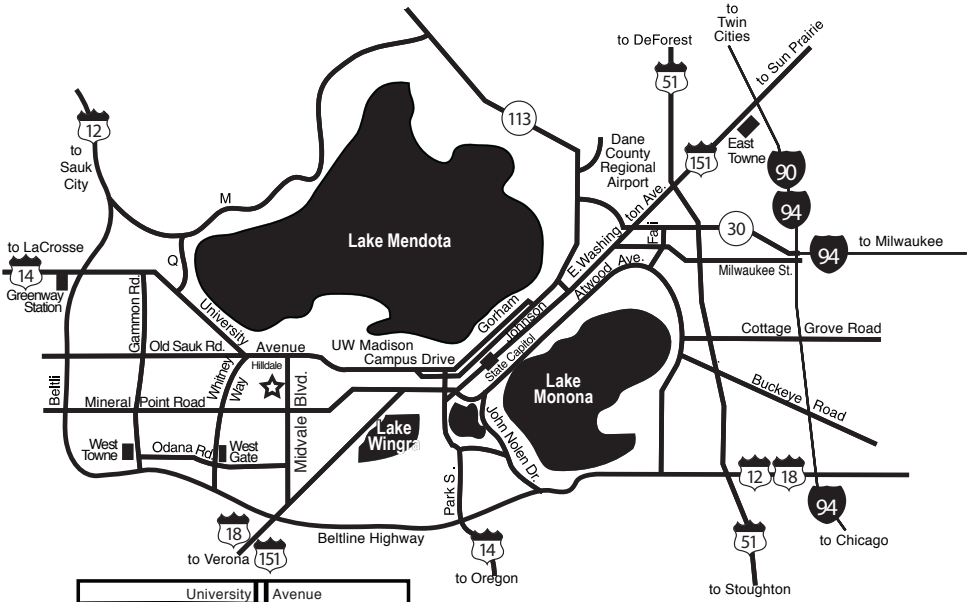
4. Tooth/Teeth # _____
   Previous RCF? Yes _____ No _____
   Radiograph/CDR available to send? Yes _____ No _____
   (If form is faxed, please mail or e-mail available films ASAP)

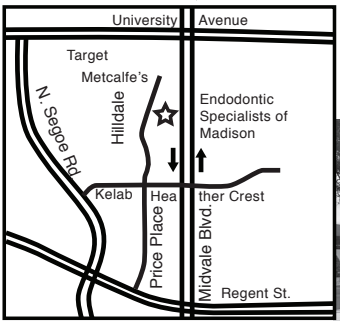
5. Reasons for referral (check all the apply):
   ____ Tooth is painful – how long?
   ____ Radiograph shows abscess
   ____ Endo necessary for reconstruction
   Post space necessary Yes _____ No _____
   ____ Vague, non-localized pain
   ____ Gum/facial swelling
   ____ Root canal treatment started
   ____ Trauma
   ____ Other: _____

6. Patient has been given Rx's for (or is taking):
   Antibiotics _____ Pain meds _____

7. Additional comments: _____
   _____
   _____

310 NORTH MIDVALE BLVD., SUITE 203, MADISON WI 53705
PHONE: 608.833.7424 / 1.800.807.7422 - FAX: 608.833.9130
www.endospecofmad.com - e-mail: esomad@tds.net
American Association of Endodontists, Specialist Member





Endodontic Specialists of Madison, 310 N. Midvale Blvd.
Enter Professional Building from southbound Midvale.