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GDC No. 77684



Endodontic Referral Form

Patient Information:

Choose your Clinic: Dorking ☐ Caterham ☐

Mr ☐ Mrs ☐ Miss ☐ Ms ☐

Surname: Forename: DOB:

Address: Postcode:

Tel (primary): Email:

Tooth requiring treatment:

Reason for Referral:

☐ Primary root canal treatment ☐ Re-treatment ☐ Diagnosis of pain ☐ Second opinion

Is the tooth symptomatic? ☐ Yes ☐ No

Other (please specify in as much detail as possible):

Radiographs included? ☐ Yes ☐ No Periapical: _____

Bitewings: ☐ Left ☐ Right

Following Endodontic Treatment:

☐ Temporary restoration ☐ Permanent core (at additional cost) ☐ Prepare post space (at additional cost)

Please note that no restoration will be carried out without the express permission of the referring general practitioner.

Other (please state):

Relevant Medical History (including medications):

Referring Dentist:

Name: Practice address:

Postcode:

Signature: Date:

By signing this form, you have confirmed you have the patient's permission to send their information on this referral

Once you have completed this form, please submit it to one of the addresses below. The contents of this form will be treated in the strictest of confidence.



Caterham
Timberhill Dental Practice
14 Timber Hill Road,
Caterham,
Surrey,
CR3 6LD
Tel: 01883 342077



Dorking
Surrey Dental Specialists
Allen Court
56A High Street
Dorking
Surrey RH4 1AY
Tel: 01306 885898