

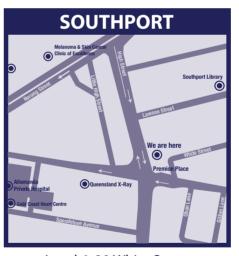
Date	•••••			
Patient Details				
Surname				
Given Name/s		DOB		
Contact telephone	number/s			
Referral is for the	following:			
☐ Root Canal Ther	ару	☐ Diagnosis /	☐ Diagnosis / Opinion	
☐ Retreatment		☐ Endodontic	☐ Endodontic Surgery	
☐ Cracked Tooth		☐ Trauma	☐ Trauma	
Tooth number/s			•••••	
Reason for referra	l			
After treatment is complete, please		☐ Refer back f	☐ Refer back for crown	
☐ Leave post space		☐ Place tempe	☐ Place temporary restoration	
☐ Place post/core build up		☐ Restore acc	☐ Restore access as needed	
Referring Dentist n	ame			
Practice phone			•••••	
Practice email				
Preferred Practice	:			
☐ Brisbane E : reception@endodonticsonly.c		icsonly.com.au	P : 07 3003 0311	
☐ Strathpine	E: reception@endodonticsonly.com.au		P : 07 3003 0311	
☐ Toowoomba	E : admin@endoonlytoowoomba.com.au		P : 07 4639 6533	
☐ Southport	E: southport@endodonticsonly.com.au P: 0		P : 07 5503 0794	
☐ Rob Hazlewood	☐ Andrew Sainsbury	☐ Jeff Hislop	☐ Bill Kahler	
☐ Andrew Thomson	☐ Kiran Kumar	☐ Tom Fenelon	☐ Unni Pillai	
☐ First Available				



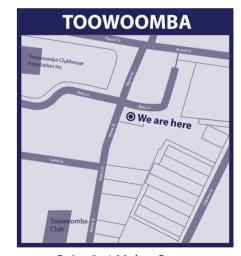
9th Floor, 141 Queen Street Brisbane Qld 4000 **Ph: (07) 3003 0311**



Unit 1, 520 Gympie Road, Strathpine Qld 4500 **Ph: (07) 3003 0311**



Level 6, 39 White Street Southport Qld 4215 **Ph: (07) 5503 0794**



Suite 2, 4 Mylne Street, Toowoomba QLD 4350

Ph: (07) 4639 6533

www.endodonticsonly.com.au

Appointment Details:

Date...... Time

