RIVERVALLEY ENDODONTICS
Harish K. Malyala, DDS

809 Wright's Summit Pkwy, Suite 110 | Fort Wright, KY 41011
Phone: 859-780-2550 | Fax: 859-261-2749
email: info@rivervalleyendodontics.com

Date of Referral: ______________________________

Patient's Name: ______________________ Phone: ______________

Referring Doctor: ______________________ Phone: ______________

Referring Doctor email: ______________________________

Appointment Date: ______________________ Time: ______________

For the endodontic consideration of the following:

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

Desired Treatment:

- ☐ Evaluation Only
- ☐ Root Canal Treatment
- ☐ Root Canal Treatment necessary for restorative reasons
- ☐ Evaluate for Retreatment
- ☐ Evaluate for Surgery

Restorative Comments:

- ☐ Prepare Post space
- ☐ Restore Access with Composite
- ☐ New Crown Planned
- ☐ Existing Restoration is:
  - ☐ Permanent
  - ☐ Permanent w/Temp Cement
  - ☐ Temporary

Dental History/Present Condition:

- ☐ Asymptomatic
- ☐ Severe Pain/Swelling
- ☐ Temperature/Pressure Sensitive
- ☐ Previous Root Canal Therapy
- ☐ Periapical Radiolucency Evident
- ☐ Carious Pulpal Exposure
- ☐ Visible Crack or Fracture
- ☐ History of Trauma
- ☐ Root Canal Initiated

Special Instructions:

- ☐ Please Call Me Prior to Treatment
- ☐ Premedication required
- ☐ Send More Referral Slips

Comments: ______________________________

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Please email referral to info@rivervalleyendodontics.com or fax referral to 859-261-2749.

Note: To refer a patient to our practice for a Cone Beam Computed Tomography (CBCT) scan, please download and complete the CBCT referral form from our practice website.