									Patient Name								
	TERRE HAUTE ENDODONTICS QUALITY • COMPASSION								Referring Doctor								
	1. E. S.		• CO						Tootl	n #				16- 77 5- 5			
Appointment Date:									Time:								
Ple	ease ci	rcle t	eeth t	o be	evalu	ated:											
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	
Pat	ient is	s bein	g refe	erred	for th	ne fol	lowin	g:									
	Evaluation Only Root Canal T							nal Tl	herapy	7	R	etreatr	nent		3	BD Scan	
Endodontic Surgery Oral or IV Se						IV See	dation		Other:								
Pat	ient p	resen	ts wit	th the	e follo	wing	cond	litions	:								
Diffuse Pain Swelling or S						g or Si	nus Ti	ract	Periapical Lesion								
Resorption Defect Trauma									Pulpotomy/Pulpectomy completed								
	Root	Cana	l The	rapy	could	l not	be co	mplet	ed du	e to:			gard) .		신문		
Suspected Cracked Tooth or Root Fracture								Other:									
W]	nen tre	eatme	ent is	comp	olete:												
Place an appropriate access restoration									Place a temporary restoration								
	Place post and core build-up as needed									Prepare a post space							
	Place	post		ore c									T	1			

1.19	Interstate 70	E	. Davis Dr.			
S US Hwy 41	E McCallilster Dr.	S 4th Street	E	Hospital Lane	Ň	Kae Fark
	Lincomiser Di	t Join Street	S Regional St center	Regional H	ospital	s /th street

www.hauteendo.com 3965 S. Regional St. Terre Haute, IN 47802 Phone: 812-235-1598 Fax: 812-235-1999 Email: office@hauteendo.com





If you are unable to keep this appointment kindly give 24 hours notice. Thank you.