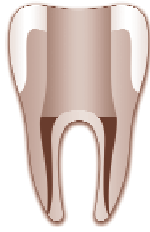

Dr. Tom Shackleton D.D.S.

General Dentist

PRACTICE LIMITED TO ENDODONTICS

Date:____

Referring doctor: ______________________________________

This is to introduce ____________________________________
to your office for endodontic examination of tooth/teeth numbers:

____

Patient Phone: Home____________ Cell____________ Work____________

Please evaluate for the following conditions/treatment:

- [ ] Periapical Radioluscency
- [ ] Elective Endodontics
- [ ] Post/File Removal
- [ ] Pulp Exposure - Please Treat
- [ ] Retreat Existing RCT
- [ ] Place Core Upon Completion of RCT
- [ ] Tooth Accessed - Please Treat
- [ ] Other

NOTES:

#18 - 3919 Richmond Road, SW, Calgary, Alberta T3E 4P2
Business: (403) 242-9952 Emergency: 616-4377 Fax: (403) 242-6975