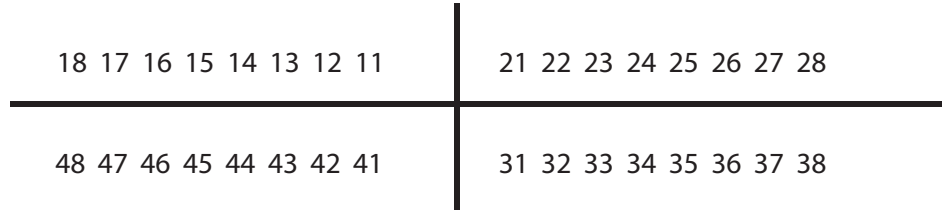




Dr. Aldo Manzur DDS, MSc, FRCD(C)
Specialist in Endodontics

Referring Doctor First Name: _____ Last Name: _____ Practice Phone No: _____
 Patient's First Name: _____ Last Name: _____ DOB: _____ Sex: M F
(MM/DD/YYYY)
 Address: _____ City: _____ Postal Code: _____
 Home Telephone: _____ Mobile: _____ Email: _____



Please ensure all fields are completed

Tooth	Consult only	Consult and Treat	Is it Vital?	Previous RCT?	Date of original treatment
	<input type="checkbox"/>	<input type="checkbox"/>	Y N Unsure	Y / N	
	<input type="checkbox"/>	<input type="checkbox"/>	Y N Unsure	Y / N	

Sensitive to: Heat Cold Pressure Percussion Biting/Chewing
Discomfort: Mild Moderate Severe Throbbing Dull ache Sharp Lingering
Meds given: Antibiotic: _____ **Started** _____
 Analgesic: _____ **Started** _____

What is the proposed restorative plan for the tooth? (Please circle)

1. A bonded composite/amalgam restoration
2. A crown
3. No plan has been discussed

After completion of the root canal procedure would you like us to? (Please circle)

1. Leave a post space or
2. Place a bonded post and core
3. Fill coronal pulp chamber with glass ionomer to be used as a base
4. Other: _____

Existing Restoration: _____

Are there any medical conditions we should be aware of?

Is your patient taking any medications? Y N If yes please specify:

Comments: _____

