



## Referral to Kathie Carson, D.D.S., M.S.

5131 River Club Drive, Suite 100, Suffolk, VA 23435 - Harbour View Suffolk

CarsonEndo.com Info@CarsonEndo.com

Phone: (757) 942-8737 Fax: (757) 282-5707

Date \_\_\_\_\_ Patient Phone # \_\_\_\_\_

Patient Name \_\_\_\_\_

Referred by Dr. \_\_\_\_\_

Patient is being referred for the following:

- Evaluation
- Root Canal Therapy
- Retreatment
- Microsurgery
- Trauma
- Other: \_\_\_\_\_

For Tooth(s) #: \_\_\_\_\_

Upper Right

1 2 3 4 5 6 7 8

32 31 30 29 28 27 26 25

Lower Right

Upper Left

9 10 11 12 13 14 15 16

24 23 22 21 20 19 18 17

Lower left

- RCT started
- Tooth Fracture
- Pulpal Exposure
- Periapical Radiolucency
- Asymptomatic
- Symptomatic
- Antibiotic Prophylaxis prior to Treatment

When treatment is complete, please:

- Restore access opening as needed
- Temporary Restoration (Type) \_\_\_\_\_
- Prepare post space
- Call concerning patient

Comments/Special Instructions

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

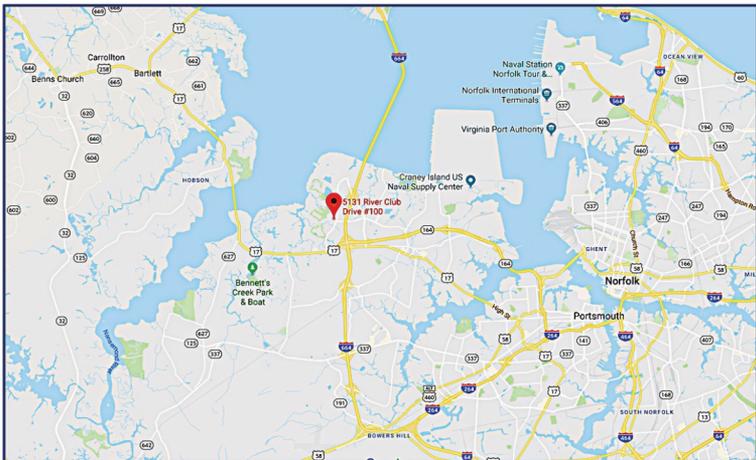
Appointment Day: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

If you are unable to keep this appointment, kindly give 24 hour notice.



## Our Practice Location

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