



Dr. Cody Heslington D.M.D.
Board Certified Endodontist
American Board of Endodontics

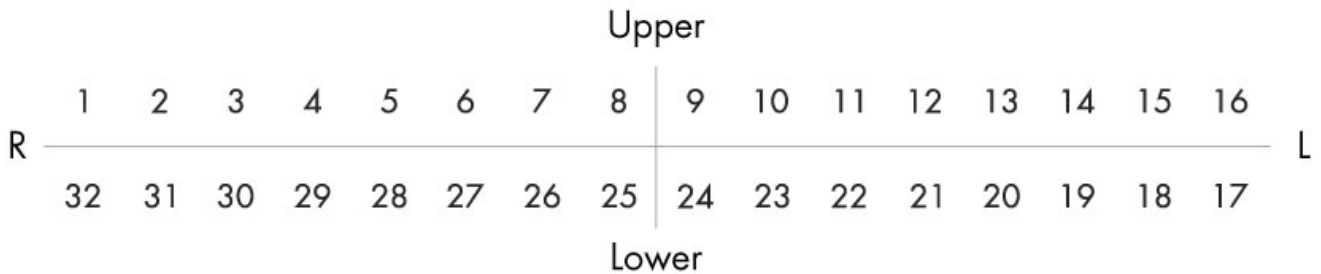
Patient name: _____ Date: _____

Kindly referred by: _____

Office phone: _____

Appointment date and time: _____

Please circle the tooth or teeth to be evaluated:



Requested treatment:

- Root canal therapy
- Retreatment
- Evaluation only
- 3D imaging
- Please call to discuss

Restorative request:

- Place core build-up and place post (if needed)
- Prepare post space only
- Repair access with:
 - Composite
 - Temporary restoration

Comments:

- Please mail treatment report
- Please email treatment report

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BRING THIS REFERRAL WITH YOU TO YOUR APPOINTMENT