



**BB Endodontics Ltd**

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**Referring dentist details**

Name:	Referral date:
Practice name:	
Address:	
	Tel:
Postcode:	E-mail:

**Patient information**

Name:	DOB:
Address:	Tel (home):
	Tel (mobile):
Postcode:	E-mail:

**Reason for referral**

<input type="checkbox"/> Consultation only
<input type="checkbox"/> Root canal treatment
<input type="checkbox"/> Root canal retreatment
<input type="checkbox"/> Endodontic surgery
<input type="checkbox"/> Trauma
<input type="checkbox"/> Removal of post or fractured instrument
<input type="checkbox"/> Other (Please give details below)

**Clinical details**

(Please specify tooth or area)

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_