

# ENDODONTIC TREATMENT REFERRAL FORM FOR DENTISTS



ICE Postgraduate  
Dental Institute  
& Hospital

## REFERRING DENTIST INFORMATION

Name

Email Address

Practice Name  
and Address

## PATIENT INFORMATION

Name and Title

Contact Number(s)

Email Address

Date of Birth

Address

## Medical History and Current Medication

## Reason for referral

## Additional details/Requests

**\*Please provide any radiographs that may be available**

## Referring Practitioner's Name

Date

## Please return this form to:

- 1) [endo@endodontistmanchester.co.uk](mailto:endo@endodontistmanchester.co.uk) or
- 2) a standard email can also be sent, but it must provide all the details requested on this form
- 3) ICE PG Dental Institute & Hospital, 24 Furness Quay, Salford Quays, Manchester M50 3XZ  
[www.icedentalimplants.co.uk](http://www.icedentalimplants.co.uk)



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