DR. LIONEL LENKINSKI
DR. MARY TAM
DR. RAMITPAL S. KHURANA

(416) 461-3636
(416) 461-ENDO

1490 Danforth Avenue, Suite 202

This is to introduce _____

for endodontic evaluation of:

1 **2**

Right

8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8

Left

4 **3**

Reason for referral:

_____

_____

_____

Patient has been informed that:

- ❑ non surgical root canal therapy required
- ❑ surgical root canal therapy required
- ❑ re-treatment of previous root canal therapy required
- ❑ emergency treatment will be rendered

I have prescribed the following medications:

Antibiotic _____

Analgesic _____

Anti-inflammatory _____

Patient would be interested in:

❑ nitrous oxide ❑ oral sedation

Crown/Bridge is cemented

❑ temporarily ❑ permanently

Need for full coverage discussed

❑ yes ❑ no

Email Xrays to:
Dr. Lenkinski
lenkinskigroup@rogers.com
Dr. Tam
xrays.3300bloor@gmail.com
Dr. Khurana
xrays.3300bloor@gmail.com

Post space required

❑ yes ❑ no

❑ **Please contact me personally**

SIGNED DR. _____

Endodontic Specialty Group

Lionel Lenkinski, D.D.S., Cert. Endo
Mary Tam, D.D.S., M.Sc., Cert. Endo
Ramitpal S. Khurana, B.D.S., D.M.D., Cert. Endo.

1490 Danforth Avenue
Suite 202, Toronto, Ontario M4J 1N4
Tel. (416) 461-3636 (416) 461-ENDO
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Referring Dr. _____

The following appointment has been reserved for you

DAY	*DATE*	*TIME*
		A.M. / P.M.
_____	_____	_____