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

(416) 232-1396
FAX: (416) 232-2302

2nd Floor, Centre Tower, Bloor Islington Place

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

Reason for referral:

____

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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

Email Xrays to:

info@endospecialist.ca

Crown/Bridge is cemented

❑ temporarily ❑ permanently

Need for full coverage discussed

❑ yes ❑ no

Post space required

❑ yes ❑ no

❑ **Please contact me personally**

SIGNED DR. ______________________________

Endodontic Specialty Group

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Fax (416) 232-2302

Referring Dr. ______________________________

The following appointment has been reserved for you

DAY	*DATE*	*TIME*
____________	____________	____________ A.M. P.M.

PARKING: UNDERGROUND ACCESS
FROM ABERFOYLE CRES. & BLOOR STREET

TRANSIT: DIRECT ACCESS
ISLINGTON SUBWAY STATION