Praxis Dr. med. dent. Amina Munir

Referral form

Patient

Surname/ First name: Date of birth:

Street, No.: Telephone number:

Postcode/ town: Email address:

Patient should be contacted via: phone ☐ post ☐ email ☐

Patient will get in touch: ☐

Practice

Dentist: Practice:

Street, No.: Telephone number:

Postcode/ town: Email address:

Referral for

Tooth/ Teeth:

Please check if applicable

Root canal treatment ☐

Retreatment ☐

Apical surgery (a consultation call before treatment is required) ☐

Vital pulp therapy: incomplete root ☐ complete root ☐

Examination and consultation regarding the treatment and prognosis of a tooth ☐

Unclear symptoms, cause of pain hard to identify ☐

Other:

Remarks:

Dear colleagues,

Please do get in touch via phone call or email, if you would like to discuss the case first or if examination and/ or treatment are required urgently.

The filled form along with the relevant radiographs may be sent via email or post.

If not specified otherwise, the access cavities will be sealed with an adhesive composite filling.

Thank you for the trustful collaboration.

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