Professional Endodontics
of pinellas county, p.a.

MARGARET H. YOUNG, D.D.S.
Root Canal Specialist
Microsurgical & Microendodontics
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Date of Referral: _____/_____/_____

Scheduled Appointment Date: _____/_____/_____ Time: _____

Referred by Dr.: _____

Patient's Name: _____

Reason for referral: (Please check appropriate boxes and circle tooth number on the right side)

- ☐ Consultation Only
- ☐ Consultation and Treatment
- ☐ Root Canal Therapy
- ☐ Retreatment
- ☐ Post Removal
- ☐ Apicoectomy
- ☐ Apexification
- ☐ Other _____

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

Please check any additional treatment options:

- ☐ Post-Prep
- ☐ Post Cementation
- ☐ Post and Core Cementation

Additional Information:

_____

_____

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NOTE: Please return to your dentist for a final restoration within 1-2 weeks following root canal treatment (unless otherwise instructed).