Bay Bloor Endodontics

60 Bloor Street West
Suite 409
Toronto, Ontario
M4W 3B8

☐ **Dr. Irwin Golosky** B.Sc., D.D.S., Cert. Endo.
☐ **Dr. Michael Ringel** B.Sc., D.D.S., M.S.D., FRCD(C)
☐ **Dr. Debra Levin** B.Sc., D.D.S., Cert. Endo., FRCD (C)

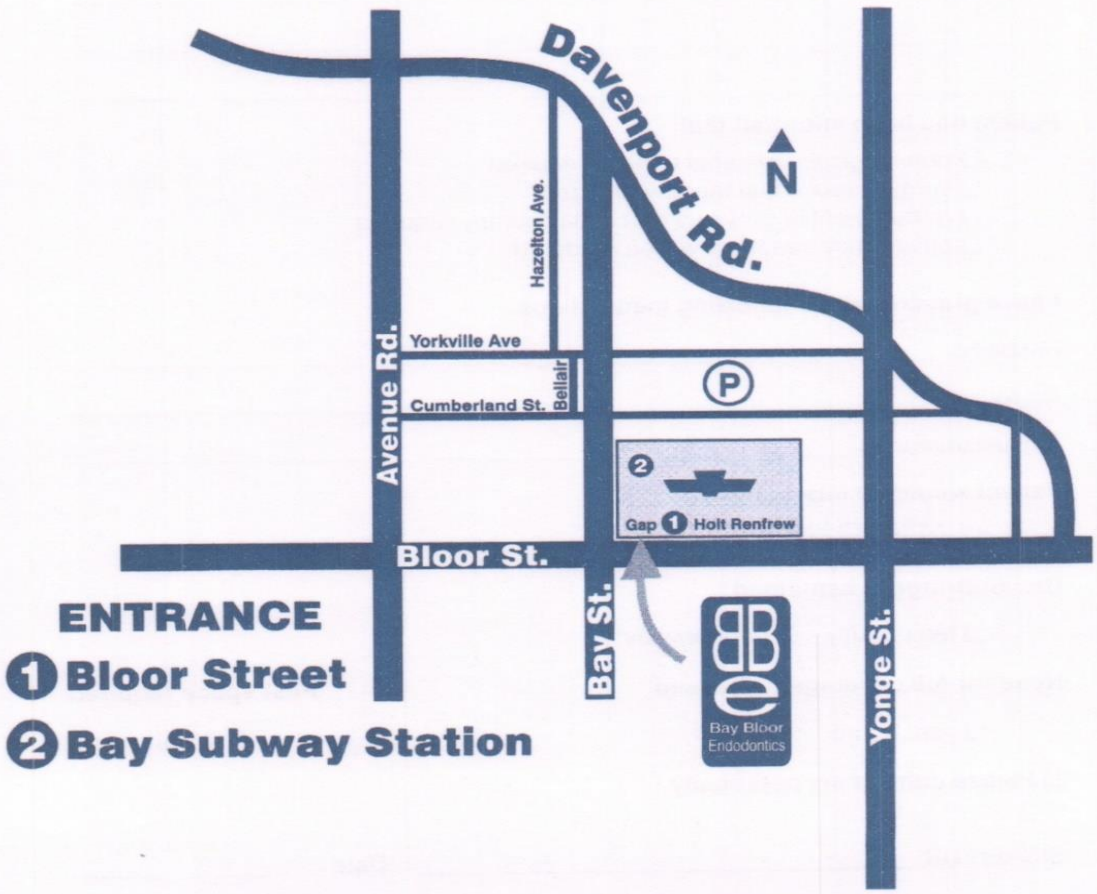
Tel: 416 925 7666 Fax: 416 925 9675

Referring Dr._____

The following appointment has been reserved for you.

Day **Date** **Time**

_____



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This is to introduce _____

for endodontic evaluation of:

	8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8	
1 Right																	Left **2**
4	8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8	**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 ❑ IV sedation ❑ general anaesthesia

Crown/Bridge is cemented

❑ temporarily ❑ permanently

Need for full coverage discussed

❑ yes ❑ no

Post space required

❑ yes ❑ no

❑ **Please contact me personally**

SIGNED DR. _____ Date _____