Bay Bloor Endodontics

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

☐ **Dr. Irwin Golosky** B.Sc., D.D.S., Cert. Endo.

☐ **Dr. Ralph Dana** B.Sc., D.D.S., M.Sc. (Endo), FRCD(C)

Tel: 416 925 7666 Fax: 416 792 0890 *email:* baybloorendo@rogers.com

Referring Dr._____

The following appointment has been reserved for you.

Day **Date** **Time**

_____

ENTRANCE

1 Bloor Street

2 Bay Subway Station

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This is to introduce _____

for endodontic evaluation of:

1 **2**

Right | Left

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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 ☐ 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 _____