



ROOT CANAL CENTER OF HALLANDALE

2500 E Hallandale Beach Blvd, Suite 812-B, Hallandale Beach, FL 33009
(954) 456-4411 | info@hallandaleendo.com

REFERRAL FORM | PAGE 1 OF 2

Endodontic referral

Complete the patient and treatment details. Check all teeth and services that apply.

PATIENT INFORMATION

First name

Last name

Date of birth

Patient / guardian phone

Patient / guardian email (optional)

REFERRING OFFICE

Referring doctor

Practice name

Office phone

Office email

TEETH AND PRIORITY

Permanent teeth

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

Primary teeth

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
A	B	C	D	E	F	G	H	I	J
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
K	L	M	N	O	P	Q	R	S	T

☐ Tooth not yet identified - evaluation requested

☐ Routine evaluation

☐ Urgent - call the office as well

Do not send completed forms, patient records, or images through general email.

Call (954) 456-4411 for secure transfer instructions. Hours: Mon-Fri 9 AM-5 PM | Sat-Sun Closed.

Dr. Felipe Gomez, DDS - General dentist; practice limited to endodontics.



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Care request and records

Select all requested services. The treating clinician determines the final care plan.

REQUESTED SERVICES

- | | |
|---|--|
| ☐ Standard root canal treatment | ☐ Retrograde filling / root-end filling |
| ☐ Endodontic retreatment | ☐ Root amputation |
| ☐ Pulpal debridement | ☐ Hemisection / bicuspidization |
| ☐ Root canal obstruction treatment | ☐ Intentional replantation |
| ☐ Pulpotomy | ☐ Internal root repair / perforation |
| ☐ Pulpectomy | ☐ Traumatic dental injury management |
| ☐ Apexification | ☐ Evaluation / diagnosis |
| ☐ Apexogenesis | ☐ 3D CBCT diagnostics |
| ☐ Apicoectomy / root-end resection | ☐ Other / please advise |

CLINICAL NOTES

Symptoms, preliminary findings, restorative plan, or requested treatment

DOCUMENTS AND RADIOGRAPHS

Please indicate records included with this referral. Use secure transfer instructions for patient records and images.

- | | | |
|---|--------------------------------------|--------------------------------------|
| ☐ Referral letter / case notes | ☐ Radiographs | ☐ CBCT export |
| ☐ Report / other document | | |

File names or additional record details (optional)

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