RIVER RUN
DENTAL

ENDODONTIC REFERRAL

Omar Gabr, DDS, MS
Board Certified Endodontist

☐ Richmond Office
804-262-1060
7820 Shrader Road,
Richmond, Virginia 23294

☐ Short Pump Office
804-390-7018
3400 Haydenpark Lane, Ste 203
Henrico, VA 23233

Date: _____ Patient Name: _____

Phone: _____ Email Address: _____

Last dental appointment date: _____

Please indicate tooth or teeth to be evaluated:

_____

Reason for referral:

- ☐ Pain/swelling
- ☐ Radiographic findings
- ☐ Pulp exposure
- ☐ Root canal necessary for restoration
- ☐ History of trauma
- ☐ Previous Root Canal Treatment
- ☐ Suspected cracked tooth
- ☐ Resorption
- ☐ Root canal initiated
- ☐ Other: _____

Requested treatment:

- Root canal treatment ☐
- Re-treatment ☐
- Apical surgery ☐
- Evaluation only ☐
- Post space requested ☐
- No orifice barrier ☐
- Please call to discuss ☐
- Place buildup ☐

Comments:

_____

_____

_____

Referred by: _____

Office phone: _____ Email: _____

☐ Please email treatment report