ASTER
DENTAL SPECIALISTS

REFERRAL FORM

DR. TAY CHIEW XSIA JOSEPHINE
BDS Malaya, MDS(Endo)(Singapore)
M Endo RCS(Edinburgh), FAMS(Endo)

SPECIALIST IN ENDODONTICS
Restricted Practice

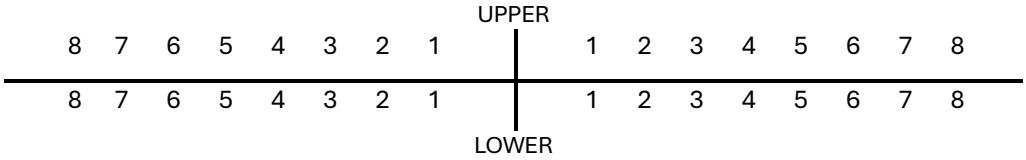
Date of Referral: _____

Patient's Name: _____ Phone: _____

Referring Dentist: _____ Phone: _____

Referring Clinic: _____ Email: _____

PLEASE MARK TOOTH/AREA OF CONCERN



TREATMENT REQUIRED

- ☐ Pain assessment/Consultation
- ☐ Root Canal Treatment
- ☐ Root Canal Retreatment
- ☐ Cracked Tooth Management
- ☐ Apicoectomy Surgery
- ☐ Post Core CR

RESTORATIVE INSTRUCTIONS

- ☐ Composite Core
- ☐ Composite Core + Post
- ☐ TD + Leave Post Space
- ☐ TD IRM / GIC

Referral Notes

_____

_____

_____

Enclosed: ☐ Intraoral radiograph ☐ CBCT

CONTACT US

Appointment Date: _____ Appointment Time: _____

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Monday – Friday: 9am – 6pm
Saturday: 9am – 1pm

THANK YOU FOR YOUR KIND REFERRAL