

Date \_\_\_\_\_

**Dr. Kiarash Shabehpour**  
DDS, DMD, MSc, Dip. Endo, FRCDC  
Certified Specialist in Endodontics

**Dr. Leslie Afable**  
DDS, MS Endo, FRCDC  
Certified Specialist in Endodontics

Patient's Name \_\_\_\_\_

DOB \_\_\_\_\_ Phone Number \_\_\_\_\_

Email Address \_\_\_\_\_

Medical Alerts/Allergies/Concerns \_\_\_\_\_

### Referring Dentist

Name \_\_\_\_\_ Clinic \_\_\_\_\_

Email \_\_\_\_\_ Phone \_\_\_\_\_

18 17 16 15 14 13 12 11    21 22 23 24 25 26 27 28  
48 47 46 45 44 43 42 41    31 32 33 34 35 36 37 38

### Preferred Restoration:

- Temporary Restoration
- Final Restoration
- Leave Space for Post
- Post and Core Build Up

### Radiographs Being Sent:

- Panoramic
- CBCT
- PA
- Bitewing

\*Images may be repeated if needed

Refer internally to additional Specialist(s) if recommended:    Yes     No

**Comments:**