DENTAL SEDATION SOLUTIONS

MOBILE SEDATION SERVICE

Referral Form

Patient Name: ____________________

Address: ____________________

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Contact Number: ____________________

DOB: ____________________

Parent / Guardian Name: ____________________

Referring Dentist: ____________________

Practice Address ____________________

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Contact Number: ____________________

Email Address: ____________________

Dentists Signature: ____________________

Reason for referral (please tick)

- ☐ Dental Phobic
- ☐ Strong Gag Reflex
- ☐ Inhalation Sedation
- ☐ Complex Treatment
- ☐ Complex MH
- ☐ IV Sedation
- ☐ Extractions Only Under GA
- ☐ Special Care Dentistry
- ☐ Patient Request

Details: (please add here what treatment/advice has been provided and what dental treatment this patient requires, any difficulties encountered and any other relevant information)

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Radiographs Available: YES | NO

If yes, are they enclosed with the referral: YES | NO

Thank you for choosing Dental Sedation Solutions as your sedation provider