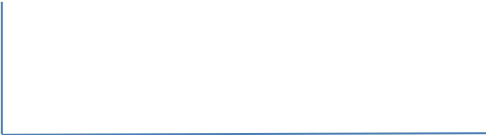

REFERRAL FOR DENTAL PROCEDURES UNDER ANESTHESIA

(Please note: Signature of Surgeon must accompany each referral request.)

Dental Office: ____

Name of Patient: ____

DOB: ________________ **Gender:** ______________________

Name of Parent/Guardian: ____

Best Contact Number(s) day of surgery: ______________________________

____

PRIMARY DIAGNOSES:

_____ **Age-related anxiety** _____**Acute reaction to stress** _____ **Other:**____________________

SECONDARY DIAGNOSES:

_____ **Dental caries** _____ **Acute periapical abscess** _____ **Chronic periapical abscess**

_____ **Other:** ____

PROPOSED PROCEDURES: ____

LENGTH OF DENTAL CASE: (including dental exam, radiographs, and procedure time in minutes)**:** ___________ **min.**

LATEX ALLERGY Precautions Needed? _____ **Yes** _____ **No**

OTHER ALLERGIES: ____

HISTORY & PHYSICAL:

Name of physician completing H&P (if known): ______________________________

If known, indicate when/where: ______________________________

Comments: ____

____

Surgeon's Signature: ______________________________ **Date:** _____________ **Time:** _______