Children's Dental
SURGERY ASSOCIATES

Referral Date: _____

Patient Name: _____ DOB: _____

Parent/Guardian Name: _____

Parent/Guardian Phone Number: _____

Referring Doctor Name: _____

Referring Practice Name: _____

Referring Practice Phone Number: _____

☐ Referring dentist understands that this practice does not offer in office treatment and is for dental surgery at surgery center or hospital.

☐ Referring dentist understands that after treatment is completed the patient will be referred back to their dental home for routine care

Reason for referral for dental surgery under general anesthesia:

Please check all that apply

☐ Severe Early Childhood Caries

☐ Child with Special Health Care Needs

☐ Unsuccessful attempts at delivering treatment in the traditional dental setting

☐ Unable to safely sedate in office

☐ Other:

Please email or fax referral directly to Children's Dental Surgery Associates in order to schedule consultation

Email: admin@iowaCDSA.com

P: 515.776.1136
F: 515.864.0507

www.iowacdsa.com