SDC Surgical and Sedation REFERRAL FORM

Patient Name: _____ Phone No: _____

Referring Doctor Name: _____ Phone No: _____

Address: _____

REASON FOR REFERRAL:

- ☐ Procedure under Oral/IV sedation
  - ☐ Restorations / Endodontics
  - ☐ Implant related surgery
  - ☐ Wisdom teeth
- ☐ Bone Graft/Sinus lifts
- ☐ Implants
- ☐ Removal of Tori
- ☐ Phobia / Gagging
- ☐ Frenectomy
- ☐ Alveoplasty
- ☐ Consultation for Cosmetic Surgery
- ☐ Full mouth rehabilitation
- ☐ TMJ Disorders
- ☐ Sleep Apnea

Area to be Assessed: _____

Does patient require premedication? Yes No

Antibiotic Used: _____

Any Medical Concerns Requiring Attention: _____

Referring Dentist's Concerns and Additional Notes: _____

_____

_____

_____

Referring Dentist's Signature: _____ **Date:** _____

SUWANEE DENTAL CARE

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