EAST BAY DENTAL SURGERY

Center For Special Needs Dentistry

30204 Industrial Pwky SW Hayward CA 94544
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www.EastBayDentalSurg.com

Date: _____

Patient Name:_____ DOB:_____

Patient Phone Number: _____

Dental Insurance: _____

Referred By:_____

Office Phone Number:_____

Referring Office Address: _____

PATIENT REQUIRES DEEP SEDATION/GENERAL ANESTHESIA FOR ORAL/DENTAL REHABILITATION

Reason for Referral:

_____ Use of effective communicative techniques and the inability for immobilization failed or was not feasible based on the medical needs of the patient.

_____Patient requires extensive dental restorative or surgical treatment that cannot be rendered under local anesthesia or conscious sedation.

_____Surgical Procedure(s) requires General Anesthesia.

_____Patient has acute situational anxiety.

_____Patient is uncooperative due to certain physical or mental compromising conditions.

_____Alternative methods were unsuccessful.

_____Local anesthetic is contra-indicated.

_____Other:

Please indicate the services requested by the referring Dentist:

_____ Complete Dental Treatment under General Anesthesia.

_____ Only the following treatment: _____

_____

Dentist Signature: _____

DIGITAL PHOTOS/X-RAYS: If X-rays or Digital Photos have been taken, please enclose with the referral.