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This is to introduce you to my patient,	
Patient Name	 Date
For:   Consultation   Treatment	
Comments	
Referring Doctor	Phone
Reason(s) for referral	
☐ Nitrous oxide analgesia	☐ Severe gag reflex
☐ IV Sedation	☐ Unable to get numb
☐ Dental phobic/anxiety	☐ Special needs patient
Instructions for IV sedation patients	Please evaluate and treat
1. Nothing to eat or drink for	☐ Patient referred for
8 hours prior to surgery.	complete dental care
2. Bring someone to stay in the office during your surgery.	<ul><li>Please refer patient back for follow-up visits</li></ul>
<ul><li>3. Patients under 18 years of age must</li></ul>	Restorative
be accompanied by a parent or	☐ Crown and Bridge
legal guardian.	☐ Dental infection/RCT
4. Patients are advised to wear loose	☐ Oral surgery
fitting sleeves.	□ Other
5. Please bring this referral sheet and any x-rays with you to our office.	