SPECIAL CARE
DENTISTRY

PATIENT REFERRAL FORM

Patient Name: _____ **Phone:** _____

Referring Office: _____

Office Number: _____

Member ID: _____ **Agency:** _____

Insurance: ☐ Medicaid ☐ Private Insurance ☐ Other _____

MCO: ☐ DentaQuest ☐ ICF ☐ Other _____

NEXT recare/recall appt. in your office: _____

Reason for Referral:

☐ Extent of treatment ☐ Severe Dental Anxiety ☐ Developmental Delay

☐ Unable to complete treatment _____

☐ Medically compromising conditions _____
(asthma, ADHD, autism, down syndrome, alzheimer's, etc.)

☐ Failed Sedation ☐ Uncooperative Behavior

☐ Other _____

☐ **Oral Conscious Sedation:** I believe this patient is a candidate for conscious sedation. In the event of failed sedation, Dental Rehabilitation under IV Sedation/General Anesthesia is requested for my patient.

☐ **IV Sedation/General Anesthesia:** I believe this patient is a candidate for Dental Rehabilitation under IV Sedation or General Anesthesia due to uncooperative behavior.

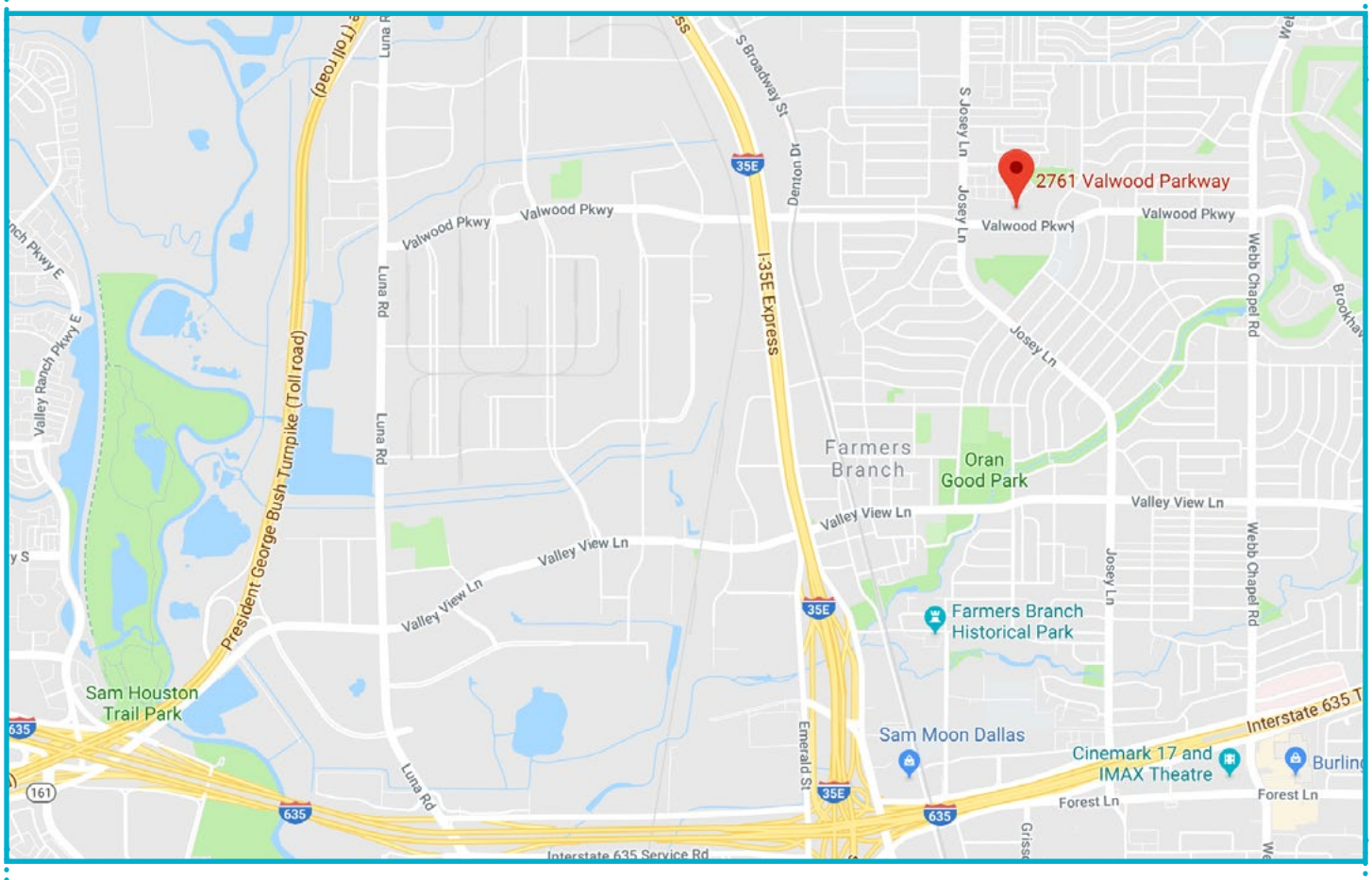
Please consult my patient

_____ _____
Doctor's name Doctor's Signature

_____
Date

WE ARE LOCATED AT

2761 Valwood Parkway
Suite 200
Farmers Branch, TX 75234



(972) 241-1111

www.specialcaredentistry.net

WE SPECIALIZE IN:

- SPECIAL NEEDS
- ADOLESCENTS
- GERIATRICS
- IV SEDATION & ANESTHESIA