Cambridge Centre

DENTAL CARE

# SLEEP DENTISTRY REFERRAL FORM

**All questions contained in this questionnaire are strictly confidential and will become part of your medical record**

| Patients Details: | Referring Dentist: |
| --- | --- |
| **Name** *(Last, First, M.I.):* | **Name** *(Last, First):* |
| **Phone Number:** | **Phone Number:** |
| **Email:** | **Email:** |
| **DOB:** | |

Referral For:

- ☐ **General Anesthesia**
- ☐ **IV Sedation**
- ☐ **Implants**
- ☐ **Other**

**Treatment Plan Included:** ☐ YES ☐ NO

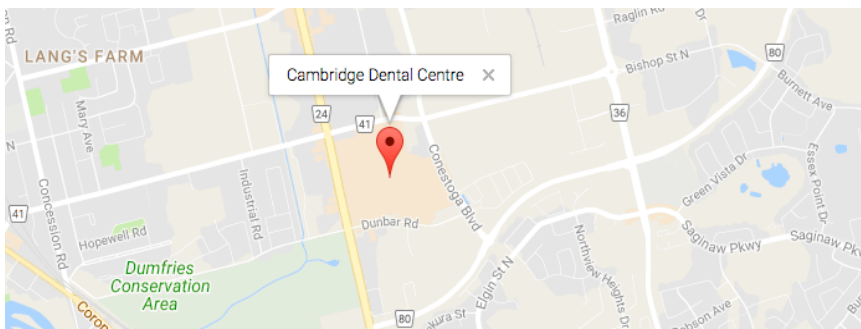
**Notes:**

Reason For Referral:

- ☐ **Anxiety**
- ☐ **Extensive Treatment Required**
- ☐ **Co-operation**

**Relevant Radiographs:**

- ☐ **Mailed**
- ☐ **Sent with patient**
- ☐ **Emailed**
- ☐ **Please take**

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(Please Forward Digital X-Rays and Treatment Plan (If Available) to: info@cambridgedentalcenter.ca)