Dental Care
CAMBRIDGE CENTRE

SLEEP DENTISTRY REFERRAL FORM

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

Patients Details	Referring Dentist:
Name *(Last, First, M.I.)*	**Name** *(Last, First)*
Phone Number:	**Phone Number:**
Email:	**Email:**
D.O.B:	

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 note**

map here

Dental Care
CAMBRIDGE CENTRE
355 Hespeler Road
Cambridge, ON N1R 6B3
Phone : (226) 539-9595
Fax : (519) 624-2264

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