Sleep Dentistry℠ of PORTLAND & VANCOUVER

PATIENT REFERRAL

Introducing: _____ Date: _____

Patient Phone #_____

Referring Dr: _____ Phone #_____

PLEASE EMAIL/FAX COMPLETED REFERRAL TO OUR OFFICE

This patient is being referred for sedation dentistry.

☐ Comprehensive ☐ Limited

Sedation for the following symptoms:

- ☐ Dental Anxiety
- ☐ Fear of Needles
- ☐ Difficulty Attaining Numbness
- ☐ Complex Dental Needs
- ☐ Strong Gag Reflex
- ☐ Highly Sensitive Teeth
- ☐ Previous Negative Dental Experience or Trauma
- ☐ Special Needs
- ☐ Other: _____

Comments: _____

_____

☐ Portland Location
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☐ Vancouver Location
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