# Hospital Pediatric Dentist

Our Speciality - Sleep Dentistry for Kids

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## Patient Referral Form

### Referring Dentist Information

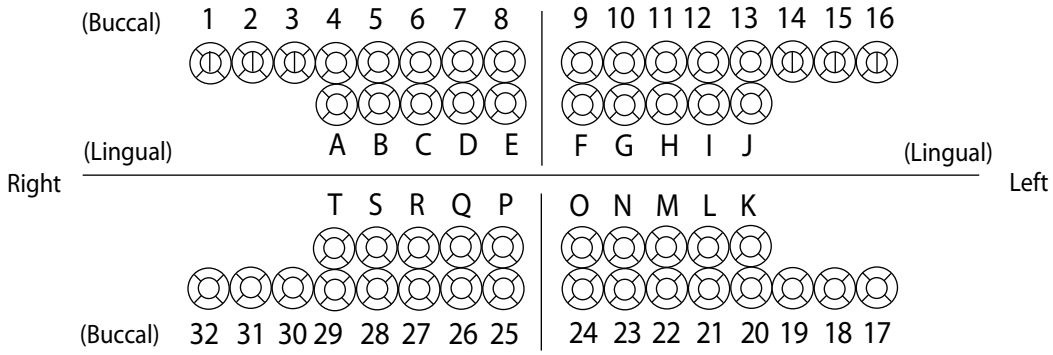
Referred by:_____ DDS, DMD, MD or Staff (Please circle one)

Office Name: _____ Telephone:_____

### Patient Information

Name:_____ Date of Birth:_____

Telephone #1:_____Telephone #2:_____




### Treatment Requirement

- ☐ 1-2 Teeth OR 1Sextants
- ☐ 3-4 Teeth OR 2-3 Sextants
- ☐ 5-8 Teeth OR 4 Sextants
- ☐ 9 or more teeth or 5-6 Sextants

### Reason for Referral

- ☐ Patient unable to tolerate dental treatment due to young age or emotional maturity.
- ☐ Patient failed conscious sedation
- ☐ Patient requires longer procedure than patient can tolerate without sedation.
- ☐ Patient has a medical condition that requires supervision
- ☐ Other_____

Doctor/Staff Signature:_____

**When complete, please fax to: 832-464-7172**