SEDATION REFERRAL FORM

PATIENT INFORMATION:

____
REFERRED BY DR. DATE

____
CLINIC EMAIL PHONE

____ ☐ M ☐ F
PATIENT NAME BIRTHDAY GENDER

____
HOME PHONE CELL PHONE WORK PHONE

18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28
48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38

REASON FOR REFERRAL:

- ☐ Anxiety/dental phobia
- ☐ Gag reflex
- ☐ Difficult to freeze
- ☐ Requires extensive treatment

____
____
____
____

SPECIAL CONSIDERATIONS:

____
____
____
____

X-RAYS:

Are recent x-rays/treatment plan available?

☐ YES ☐ NO

CHINOOK SMILES
Unit 408, 6455 Macleod Trail SW
Calgary, AB T2H 0K9
T: 403-252-1404 F: 403-252-1996
info@chinooksmiles.ca