Griffith Collaborative Group
Sedation Dentistry
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Date_____ Patient:_____ Date of Birth: _____

Contact person's Name: _____ Phone: _____

Referred by:_____ Doctor's Office Phone: _____

Doctor's Email Address: _____

Reason for Referral:

This patient will go back to the referring doctor after treatment is completed.

☐ **Yes** ☐ **No**

Date of Current x-rays: Bitewings _____ Periapical _____ Pano _____

Recommended Treatment and Remarks: