FRESNO DENTAL
SURGERY CENTER
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Referrals@dentalasc.com
www.fresnodentalasc.com

REFERRAL SLIP

**Please include treatment plan + x-rays if available w/ this form.*
Failure to complete this form will cause delays.

Referred By: _____

Referred Address: _____

_____

Referred Phone: _____

Patient Name: _____ DOB: _____

Parent Name: _____

Phone #1: _____ Phone #2: _____

Patient's Address: _____

_____

Insurance Name: _____

Insurance ID#: _____

REFERRED FOR GENERAL ANESTHESIA DUE TO THE FOLLOWING:
(Check all that apply. Must be both 1 AND 2 or any one of the remainder)

- ☐ 1. Use of local anesthesia to control pain failed, OR was not feasible based on medical needs of patient
- ☐ 2. Use of conscious sedation, either inhalation or oral, failed, OR was not feasible based on medical needs of patient
- ☐ 3. Use of effective communicative techniques and the inability for immobilization (Patient may be dangerous to self or staff) failed or was not feasible based on the medical needs of the patient
- ☐ 4. Patient requires extensive dental restorative or surgical treatment that cannot be rendered under local anesthesia or conscious sedation
- ☐ 5. Patient has acute situational anxiety due to immature cognitive functioning
- ☐ 6. Patient is uncooperative due to certain physical or mental compromising conditions
- ☐ Other: _____

MANAGEMENT METHODS ATTEMPTED

- ☐ Local Anesthetic Number of Attempts: _____
- ☐ Nitrous Oxide
- ☐ Oral Sedation
- ☐ Other: _____

BRIEF MEDICAL/DENTAL HISTORY

_____

_____

_____

_____

DOCUMENTATION THAT SUPPORTS ABOVE:

_____

_____

Referring Doctor's Signature: _____ **Date:** _____

Please FAX or E-mail this form with treatment plan + x-rays if available to: (559) 263-9777 or Referrals@dentalasc.com