# IV SEDATION REFERRAL

Dr. Ruby Bhullar DMD, AFAAID

360 Dental Specialists

**REFERRING DENTIST INFORMATION**

Dentist Name _____

Office Name _____

Phone Number _____

E-mail _____

**PATIENT INFORMATION**

Full Name _____

Address _____

City _____ PC _____

Phone Number _____

E-mail _____

**INSURANCE INFORMATION**

Policy Holder's Name _____

Policy Holder's DOB _____

Insurance Company _____

Plan/Policy # _____

ID/Certificate _____

**REASON FOR REFERRAL**

___ Severe Dental Anxiety

___ Severe Gag Reflex

___ Unable to Complete Treatment

___ Failed Sedation Attempt

___ Hard to Freeze

___ Other

**TREATMENT NEEDED**

___ Fillings

___ Tooth Extractions

___ Wisdom Tooth Extractions

___ Bone Grafting

___ Implants

___ Other

**NOTES**

_____

_____

_____

_____

_____

_____

**X-RAYS**

___ Not Available

___ Attached to E-mail

**360 Dental Specialists /** Unit B225 – 3122 Mount Lehman Road / **Abbotsford**, BC V2T 0C5 / T: 604-381-3399 F: 604-381-3393