



# IV SEDATION REFERRAL FORM

DATE: \_\_\_\_\_

*For IV Sedation Consultations & Treatment*



2691 Pandosy Street, Kelowna, BC V1Y 1V8



778-478-2273



smile@cairedental.ca

## PATIENT INFORMATION

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Email: \_\_\_\_\_

## REFERRING DENTIST

Dentist: \_\_\_\_\_

Clinic Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

## REASON FOR REFERRAL

- Dental Anxiety / Phobia
- Previous Difficult Dental Experiences
- Other: \_\_\_\_\_
- Strong Gag Reflex
- Special Needs / Accommodations \_\_\_\_\_
- Extensive Treatment Required
- Patient Preference

## TREATMENT REQUESTED

- IV Sedation Consultation Only
- Restorative Treatment (Fillings)
- Comprehensive Treatment
- Extractions
- Root Canal Treatment
- Other: \_\_\_\_\_
- Wisdom Teeth Removal
- Crown / Bridge Treatment \_\_\_\_\_

## TEETH / TREATMENT DETAILS Please include teeth numbers and a brief description of the treatment required.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## RECORDS & IMAGING

Please email all relevant radiographs, CBCT scans, clinical photos, treatment plans, and supporting records to:

**smile@cairedental.ca**

## PATIENT SCHEDULING NOTES Any scheduling preferences or additional notes for our team.

\_\_\_\_\_

\_\_\_\_\_

## INSURANCE INFORMATION

PRIMARY INSURANCE	SECONDARY INSURANCE
Insurance Provider: _____	Insurance Provider: _____
Policy #: _____	Policy #: _____
ID / Certificate: _____	ID / Certificate: _____
Subscriber Name: _____	Subscriber Name: _____
Subscriber DOB: _____	Subscriber DOB: _____



Please email all radiographs, photos and supporting records to:

**smile@cairedental.ca**

*Thank you for trusting Care Dental with your patient's care.*

**Our team will contact the patient directly to arrange a sedation consultation and provide a treatment summary following treatment.**