HILL DENTAL WELLNESS
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Sedation/Treatment Referral Form

Patient Name_____ DOB:_____ Date_____

Referred By_____ Office Phone #:_____

Reason for Referral:

- ☐ Anxiety / Fear
- ☐ Difficulty getting numb
- ☐ Complex dental needs
- ☐ Severe gag reflex
- ☐ Limited opening
- ☐ Needle phobia
- ☐ Other_____

Radiographs:

- ☐ Please Obtain
- ☐ Patient to bring
- ☐ Emailed to office

Treatment Recommendations

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Significant Medical History/Remarks:

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