Cambridge Centre

DENTAL CARE

SLEEP DENTISTRY REFERRAL FORM

All questions contained in this questionnaire are strictly confidential and will become part of your medical record

Patients Details:	**Referring Dentist:**
Name *(Last, First, M.I.):*	**Name** *(Last, First):*
Phone Number:	**Phone Number:**
Email:	**Email:**
DOB:	

Referral For:

	☐ **General Anesthesia**	☐ **IV Sedation**
	☐ **Implants**	☐ **Other**

Treatment Plan Included: ☐ YES ☐ NO

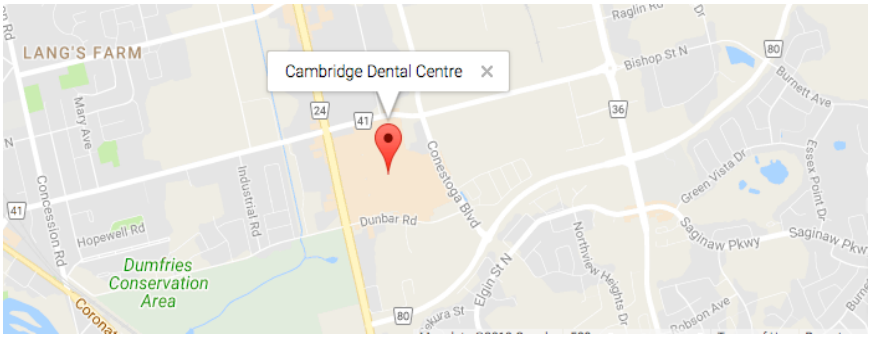
Notes:

Reason For Referral:

	☐ **Anxiety**	☐ **Extensive Treatment Required**
	☐ **Co-operation**	

Relevant Radiographs:

	☐ **Mailed**	☐ **Sent with patient**
	☐ **Emailed**	☐ **Please take**



Cambridge Centre Dental Care

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(Please Forward Digital X-Rays and Treatment Plan (If Available) to: info@cambridgedentalcenter.ca)