RUTLAND DENTAL CENTRE

DENTAL SEDATION REFERRAL FORM

MSP#

Patient Name

First Last

Gender ☐ Male ☐ Female Date of Birth: _____/_____/_____

Guardian Name

First Last

Address

Street Address

Address Line 2

City State

Province Region

ZIP/Postal Code Country

Home Phone

Business Phone

Cell Phone

Body Mass Index

A BMI > 35 may require consultation with an Anesthesiologist

Measured Height in cm Measured Weight in kg

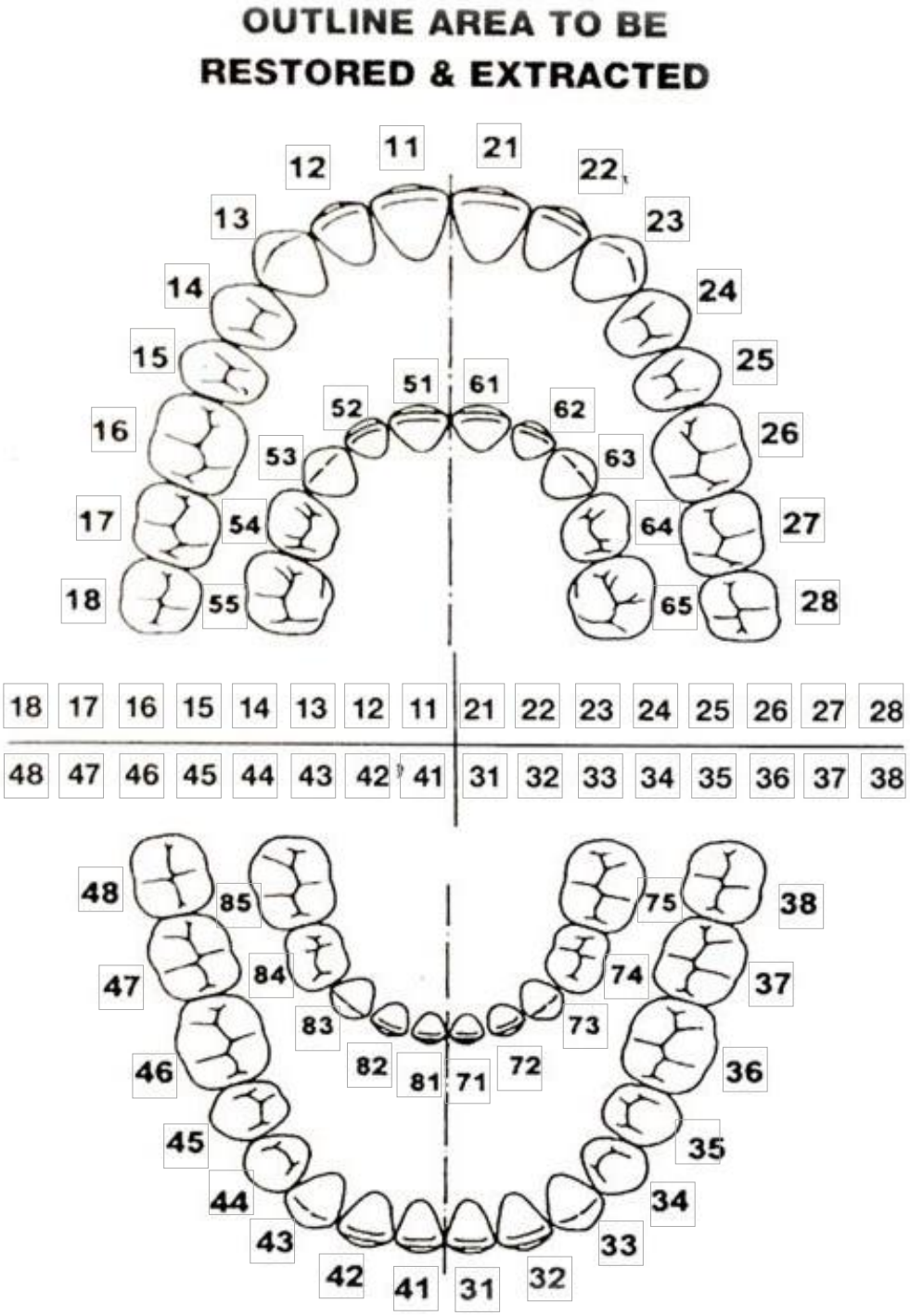
Adult BMI Child BMI

Insurance Information

First Carrier	
Insured Name	
Insured Birth Date	
Employer	
Group#	
ID#	
Dependant#	
% of Coverage	
Second Carrier	
Insured Name	
Insured Birth Date	
Employer	
Group#	
ID#	
Dependant#	
% of Coverage	

Reason For Referral

Please circle the area to be restored & extracted on the following diagram or provide a similar graphic.



Special Medical Alerts & Relevant History

Special Medical Alerts

History

Referring Doctor

Referred by Doctor

Phone

Email of Referring Dental Office

We endeavor to send treatment reports vie email

Digital Radiographs

- ☐ Digital radiographs will be sent via email
- ☐ Radiographs attached
- ☐ Patient will bring radiographs
- ☐ Please take radiographs