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:

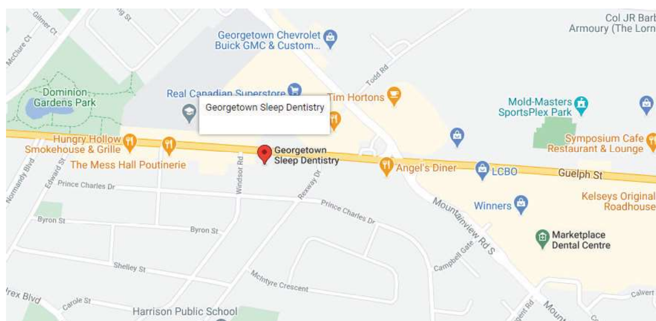
☐ Anxiety ☐ Extensive Treatment Required

☐ Co-operation

Relevant Radiographs:

☐ Mailed ☐ Sent with patient

☐ Emailed ☐ Please take



Georgetown Sleep Dentistry
174 Guelph St, Georgetown, ON L7G 4A7
Phone: (289) 891-6669
Fax: (289)-891 -6698

Please Forward Digital X-Rays and Treatment Plan (If Available) to:

INFO@GEORGETOWNDENTIST.CA