Fresno Dental Surgery Center
2828 Fresno St. Suite 100
Fresno, CA 93721
Phone: 559-263-9648
Fax: 559-263-9777
www.fresnodentalasc.com

"Your Child's Care is our First Priority"

REFERRAL SLIP

Patient Name: _____

Parent Name: _____

Referred By: _____ Phone #1: _____ Phone #2: _____

Referral Address: _____ Address: _____ Zip Code: _____

_____ Patient DOB: _____ Patient SSN: _____

Referral Phone: _____ Insurance Name and ID #: _____

REFERRED FOR GENERAL ANESTHESIA DUE TO THE FOLLOWING:
(Check all that apply. Must be both 1 AND 2 or any one of the remainder)

- ☐ 1. Use of local anesthesia to control pain failed, OR **was not feasible** based on medical needs of patient
- ☐ 2. Use of conscious sedation, either inhalation or oral, failed, OR **was not feasible** based on medical needs of patient
- ☐ 3. Use of effective communicative techniques and the inability for immobilization (Patient may be dangerous to self or staff) failed or was not feasible based on the medical needs of the patient
- ☐ 4. Patient requires extensive dental restorative or surgical treatment that cannot be rendered under local anesthesia or conscious sedation
- ☐ 5. Patient has acute situational anxiety due to immature cognitive functioning
- ☐ 6. Patient is uncooperative due to certain physical or mental compromising conditions
- ☐ Other: _____

MANAGEMENT METHODS ATTEMPTED

- ☐ Local Anesthetic Number of Attempts: _____
- ☐ Nitrous Oxide
- ☐ Oral Sedation
- ☐ Other: _____

BRIEF MEDICAL/DENTAL HISTORY (ATTACH PROBLEM LIST IF NECESSARY):

_____

_____

_____

DOCUMENTATION THAT SUPPORTS ABOVE:

_____

_____

☒ Provider Attestation: Based on my clinical knowledge and expertise, I am referring this patient to have dental treatment under General Anesthesia.

Referring Doctor's Signature: _____ **Date:** _____