Fresno Dental Surgery Center
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Independently owned & operated with a passion for treating children.

REFERRAL SLIP

Date: _____

Referred by: _____ ☐ DDS ☐ Social Worker
Referred Address: _____ ☐ DMD ☐ Case Manager
Referred Phone: _____ ☐ MD

Patient Information

Patient Name: _____ Phone #: _____
Parent Name: _____ Phone #: _____
Address: _____ DOB: _____ Social Security Number: _____

Reasons for Referral

- ☐ Patient is unable to tolerate routine dental treatment due to young age
- ☐ Patient is uncooperative and combative
- ☐ Patient requires a longer appointment than he/she can tolerate without sedation
- ☐ Patient has a medical condition requiring medical supervision
- ☐ Patient is mentally / physically handicapped and requires general anesthesia for management
- ☐ Patient is allergic to local anesthetic solutions
- ☐ Patient cannot be adequately anesthetized with local anesthetic alone
- ☐ Patient has acute dental phobia
- ☐ Surgical procedure(s) require general anesthesia
- ☐ Other: _____

_____

Treatment Needed

☐ Dental treatment ☐ Return to referring Dr. after completed treatment
☐ Other: _____

Brief Medical / Dental History (Please attach a problem list if necessary)

_____
_____
_____
_____
_____
_____
_____

Methods Used to Attempt Conventional Dentistry:

- ☐ N202
- ☐ Papoose Board
- ☐ Show-Tell-Do Method
- ☐ Oral Pre-Medication

Other: _____
_____
_____
_____

Outcome of Attempted Treatment:

_____
_____
_____

Signature: _____

FDSC Office Use Only

Rcvd: