HAPPY CHILDREN
PEDIATRIC DENTAL SEDATION CENTER

IV SEDATION– REFERRAL FORM

REFERRING OFFICE INFORMATION:

Office Name: _____Referring Doctor: _____

Phone: _____ Fax: _____ Office Email: _____

PATIENT INFORMATION:

Patient's Name: _____ Gender: Male/Female

Birthdate: _____ Age: _____ Weight: _____

Parent/Guardian Name: _____ Birthdate: _____

Address: _____

_____

Phone: _____Email: _____

Pain: YES NO **History of Abscess/Facial Swelling:** YES NO **Urgent:** YES NO

Next Available: YES NO **Treatment Plan:** YES NO **Radiographs:** YES NO

If no to treatment plan, please add recommend treatment below:

_____

_____

_____

Significant Medical History :

_____

_____

_____

Please email the completed referral along with the treatment plan and radiographs to sedation@happychildrensdentist.com . Once the referral is received, our office will contact the patient to schedule the consultation appointment.

Thank you so much for your referral!

4375 Cobb Parkway Suite 110 Atlanta, Ga 30339 Phone: 770-541-9131 Fax: 770-541-9132

Email: sedation@happychildrensdentist.com Website: https://www.happychildrensdentist.com