**IV Sedation Referral Form**

Referring Dentist Information

* Full Name:
* Practice Name:
* Practice Address:
* Phone Number:
* Email Address:
* GDC Number:

Patient Information

* Full Name:
* Date of Birth:
* Phone Number:
* Email Address:
* Address:
* Relevant Medical History
* Weight/Height
* Is the patient aware of and consents to IV sedation? (Yes/No)

Treatment Required Under Sedation

* ☐ Extractions
* ☐ Complex Restorative Work
* ☐ Hygiene Treatment
* ☐ Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Upload Supporting Documents

* Medical Summary
* Radiographs (if applicable)
* Treatment Plan

Additional Notes: