

Please Fax to: (760) 396-5723
or email to: info@Indiosurgerycenter.com

Indio Surgery Center Referral

46-900 Monroe St., Ste. B-201, Indio, CA 92201
Phone (760) 396-5733

Referral Slip for Dental Treatment Under General Anesthesia

Dentist's Name	
Address	
City / ZIP	
Phone Number	Fax#

- | | |
|--------------------------|--|
| <input type="checkbox"/> | X-Rays enclosed
Number of films _____ |
| <input type="checkbox"/> | Please Return X-Rays |
| <input type="checkbox"/> | Please take required X-Rays |
| <input type="checkbox"/> | Send more Referral Forms |

Patient's Name	Patient DOB
Address	
City / Zip	Phone Number
Primary Language	Parent Email
Parent Name / Guardian	Cell Phone Number

Patient Insurance Type:
<input type="checkbox"/> PPO <input type="checkbox"/> HMO <input type="checkbox"/> Straight Medi-Cal
<input type="checkbox"/> Other: _____
Insurance Carrier:
Subscriber ID#
Issue Date:

Patient Management Methods Attempted

- Nitrous Oxide
 Oral Sedation
 Local Anesthetic
 Other: _____

Proposed Dental Treatment Plan

Please list the number of attempts _____

Referred for General Anesthesia for the Following Reason(s):

(Check all that apply. MUST be #1 and #2 or any one of #3-#6.)

1. Use of local anesthesia to control pain failed, or was not feasible based on the medical needs of the patient.
 2. Use of conscious sedation, either inhalation or oral, failed or was not feasible based on the medical needs of the patient.
 3. Use of effective communicative techniques and the inability for immobilization failed (patient may be dangerous to self or staff) or was not feasible based on the medical needs of the patient.
 4. Patient requires extensive 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.

Documentation that supports above: _____

Provider Attestation: Based on my clinical knowledge, experience and expertise, I am referring this patient to have dental treatment under general anesthesia.

Referring Dentist's Signature _____

Date _____

Bring any information with you regarding your treatment, such as: referral, x-ray, medical history including medications, allergies, etc. If you are under 18, you must bring a parent with you.