GENERAL ANESTHESIA (GA) DENTAL REFERRAL FORM

For Referring Dental Clinics • Confidential — For Clinical Use Only

Date of Referral: _____ Referring Dentist (Print): _____

1. REFERRING CLINIC INFORMATION

Referring Clinic Name * | **Referring Dentist Name** *

Clinic Address

Phone * | **Fax** | **Email** *

_____ _____ _____

Referring Coordinator Name (optional)

2. PATIENT INFORMATION

Patient First & Last Name * | **Date of Birth**

Phone * | **Fax** | **Email** *

_____ _____ _____

Consent to text/email appointment reminders? *

■ Yes ■ No

3. PARENT / GUARDIAN (IF MINOR OR DEPENDENT)

Guardian Name | **Relationship to Patient**

Guardian Phone | **Guardian Email (optional)**

4. REFERRAL REASON & URGENCY

Reason for GA Referral * (check all that apply)

■ Severe dental anxiety / phobia	■ Extensive treatment needs
■ Special healthcare needs / limited cooperation	■ Failed treatment attempts with LA/sedation
■ Medical indication (specify below)	■ Other (specify below)

Medical indication / Other — specify

Urgency Level *

■ Routine (4–12 weeks) ■ Semi-urgent (2–4 weeks) ■ Urgent (pain / infection / swelling)

Current Symptoms (check all that apply)

■ Pain	■ Swelling	■ Fever
■ Drainage	■ Trauma	■ Other

Antibiotics prescribed?	**Analgesics prescribed?**
■ Yes ■ No	■ Yes ■ No
If yes — name, dose, start date: _____	If yes — name & dose: _____

5. DENTAL INFORMATION & TREATMENT REQUESTED

Chief Dental Concern / Diagnosis *

Radiographs Available? *

■ Yes — attached below ■ Yes — will send separately ■ No

Treatment Requested Under GA * **(check all that apply)**

■ Comprehensive exam + radiographs (if needed)	■ Restorations
■ Extractions	■ Endodontics
■ Stainless steel crowns	■ Space maintainers
■ Scaling / debridement	■ Other (specify below)

Other treatment — specify

Preferred Approach (optional)

■ Definitive treatment in 1 visit where possible	■ Call referring office before changes to plan

Antibiotic Prophylaxis Required?

■ Yes ■ No ■ Unknown

Special Notes / Additional Instructions

6. BEHAVIOURAL / ACCESSIBILITY CONSIDERATIONS

Level of Cooperation *

■ Cooperative ■ Limited ■ Unable to tolerate care awake

Triggers / Sensory Concerns

Mobility / Accessibility Needs

Communication Considerations (AAC, interpreter, etc.)

7. ATTACHMENTS

Strongly recommended — please include where possible

Radiographs (PA / BWX / Pano / CBCT)	■ Attached ■ Will send separately ■ N/A
Referral Letter / Clinical Notes	■ Attached ■ Will send separately ■ N/A
Medical Clearance Letter (if available)	■ Attached ■ Will send separately ■ N/A
Clinical Photos (if relevant)	■ Attached ■ Will send separately ■ N/A

8. ACKNOWLEDGEMENTS & CONSENT

Referring Clinic Confirms * **(all must be checked)**

■ Information provided is accurate to the best of our knowledge

■ Patient / guardian has been informed of this GA referral

■ Patient understands a consultation may occur prior to booking

Permission to request records from physician / specialist as needed *

■ Yes ■ No

9. SUBMISSION

Date of Referral *

_____

Referring Dentist Signature / Printed Name *

_____

Please fax, email, or upload this completed form with any attachments. We will contact the patient / guardian within 2 business days of receipt.

Required fields are marked * — incomplete referrals may delay processing.