SLEEP & SEDATION FOR DENTISTRY

For Teens & Adults of Lower Mainland BC

Anesthesia Referral Service

Dr. Sepehr Zahedi
DDS, MSc Dental Anesthesia

1-4361 Kingsway, Burnaby, BC V5H 1Z9
Phone: 604-568-8898
Fax: 604-432-9231
Email: info@sleepdental.ca
www.sleepatdentist.com

Patient's Name: _____ Referring Dr: _____

Patient's Phone #: _____ Doctor's Phone #: _____

Tooth/Teeth To Be Evaluated:

8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8

Special Care Individually Tailored To Each Patient's Needs

Reason for Referral:

- ☐ High Anxiety
- ☐ Severe Gag Reflex
- ☐ Uncooperative
- ☐ Surgical or Extended Dental Treatment
- ☐ Local Anesthesia Failure
- ☐ Other

Radiographs:

- ☐ X-Rays Mailed/Emailed
- ☐ X-Rays Sent with Patient
- ☐ Please take X-Rays

Special Instructions: _____

_____

Following completion of care, would you like the patient referred back to your office for regular care? ☐ Yes or No ☐

Appointment:

☐ Patient will contact you ☐ Contact patient

Signature: _____ **Date:** _____

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