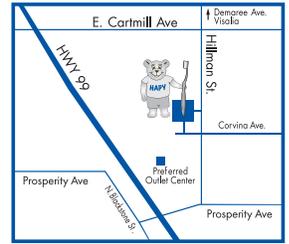




www.hapybear.com / referrals@hapybear.com



1979 Hillman St, Tulare, CA United States, 93274

Referral Slip for Dental Treatment under General Anesthesia:

Please Fill In ALL Sections Completely

Patient name: _____ D.O.B.: _____

Parent/Legal guardian: _____

Cell Phone: _____ Phone: _____

Management methods attempted: [] None/Unable to Attempt
[] Oral Sedation [] Nitrous Oxide [] Local Anesthetic [] Other: _____

Reasons for Referral (check all that apply):

- [] Mental/Physical Disability [] Autism/Developmentally Delayed [] Other Special Needs
[] Anxious/Phobic [] Uncooperative [] Young Age (<7)
[] Extensive Decay [] Surgical Procedure [] Abscess/Infection
[] Severe Gag reflex [] Other: _____

Please indicate the services requested:

- [] Diagnose and treat all necessary Dental Concerns under General Anesthesia.
[] Complete only the following treatment under General Anesthesia: _____
[] Evaluate for tongue/lip tie release. (Frenotomy/Frenectomy)

Date of last prophylaxis?: _____ X-rays taken?: [] Yes [] No Date: _____

Prescriptions given?: Antibiotic: [] Yes [] No Medication & Date: _____

Pain Medication: [] Yes [] No Medication & Date: _____

*Child must be accompanied by a biological Parent or Legal Guardian. Parent or legal Guardian must bring valid I.D., Insurance Cards and this Referral Form.

Referring Doctor/Office: _____

Phone: _____

Date: _____

