



THE DENTAL  
ANESTHESIA CENTER

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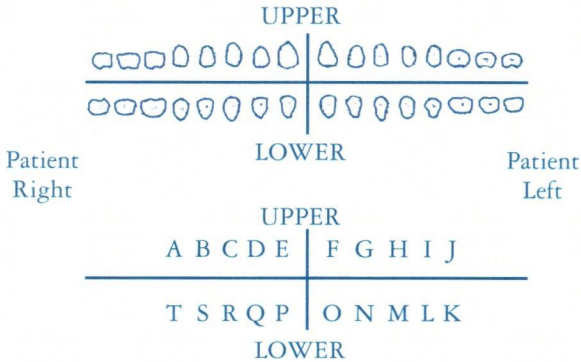
Date: \_\_\_\_\_

Dr. \_\_\_\_\_  
(Referring Dentist)

would like to refer: \_\_\_\_\_

to The Dental Anesthesia Center for consultation regarding General Anesthesia/Sedation for the following:

- \_\_\_\_\_ Pediatric Patient (unable to cooperate)
- \_\_\_\_\_ Special Needs
- \_\_\_\_\_ Severe Gag Reflex
- \_\_\_\_\_ Complications with Local Anesthesia
- \_\_\_\_\_ Medically Complex
- \_\_\_\_\_ Severe Dental Anxiety
- \_\_\_\_\_ Extensive Treatment Plan



Digital radiographs of diagnostic quality are available.  
Please email radiographs and treatment requested to [secure@dac950.com](mailto:secure@dac950.com)  
Additional Comments \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Advise your patient or their guardian to call for a pre-operative consultation.