



# Children 1st Dental & Surgery Center

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## Referral Slip

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

Referred By: \_\_\_\_\_

DDS

Social Worker

Address: \_\_\_\_\_

DMD

Case Manager

Telephone: \_\_\_\_\_

MD

### Patient Information

Patient Name: \_\_\_\_\_

Phone 1: \_\_\_\_\_

Parent Name: \_\_\_\_\_

Phone 2: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

SSN: \_\_\_\_\_

### Treatment Needed

Dental Treatment

Return to referring Dr. after completion of treatment

Other: \_\_\_\_\_

### Reason for Referral

Patient is unable to tolerate dental treatment due to young age

Patient is uncooperative or combative

Patient procedure requires a longer appointment than he/she can tolerate without sedation

Patient has a medical condition requiring medical supervision

Patient is mentally/physically handicapped and requires general anesthesia for management

Patient is allergic to local anesthesia

Patient cannot be adequately anesthetized with local anesthetic alone

Patient has acute dental phobia

Surgical dental procedure(s) require general anesthesia

Other: \_\_\_\_\_

### Brief Medical/Dental History (please attach Problem List if applicable)

### Behavioral Methods Used to Provide Conventional Dentistry

N2O2

Papoose Board

Show-Tell-Do Method

Oral Pre-Medication

Other:

### Outcome of Attempted Treatment

Signature: \_\_\_\_\_