



DR. PETER PHAM

ONSITE IV SEDATION &
DENTAL SURGERY

Patient Name: _____ DOB: _____ Referral Date: _____

PLEASE ATTACH A COMPLETED MEDICAL HISTORY FORM AND PANORAMIC X-RAY (PANO) WHEN SUBMITTING THIS REFERRAL FORM.

Medical History Concerns

Diagnosis (Check all that apply)

- Dental Caries Non-Restorable Tooth Impacted Tooth Malpositioned
 Periapical Abscess/Infection Root Fracture Failed Root Canal
 Periodontally Involved Pericoronitits Supernumerary
 Other: _____

Procedures Requested

- Extraction Tooth # _____
 Bone Graft Tooth # _____
 Dental Implant Tooth # _____
-

IV Sedation: Yes No

Temp Partial / Immediate Denture: Yes No

Other Requested Treatment Or Pertinent Details
