Sleep Dentistry
OF SPOKANE

3143 East 29th Ave.
Spokane, Washington 99223
Phone : 509.536.5900
Fax : 509.534.1015

Patient Referral Form

Patient Name : _____ First _____ Last

Date of Birth : _____

Patient Contact : _____ Phone Number _____ Email

Provider's Name : _____

Office Name : _____

Return of Patient:

- ☐ Return of patient not required
- ☐ As a patient of record, return to my office

Radiographs:

- ☐ Faxed to (509) 534-1015
- ☐ Emailed to Xrays@sleepdentistryspokane.com

Sedation Reason:

- ☐ Extensive Dental Disease
- ☐ Dental Phobia
- ☐ Age / Behavior Management
- ☐ Developmental Disability
- ☐ Other : _____

Referred For:

- ☐ Extractions
- ☐ Restorative
- ☐ Endodontic Therapy
- ☐ Other: _____
- ☐ Implant / Pre-Prosthetic Evaluation
- ☐ Frenectomy / Apicoectomy
- ☐ Emergency Evaluation Pain/Swelling

Treatment Area:

RIGHT															LEFT
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
			T	S	R	Q	P	O	N	M	L	K			

Provider Notes / Existing Treatment Plan:

Please print and fax completed form to Sleep Dentistry of Spokane at (509) 534-1015