



Sedation Referral
Knoxville Implant Dentistry
Joe F. Griffin, II, D.D.S.

Referring Practitioner

Name _____
Address _____
_____ Zip Code _____

Date _____
Tel _____
Fax _____
Email _____

Patient Details

Name _____
Address _____
_____ Zip Code _____

Home _____
Work _____
Cell _____
Email _____

Relevant Medical History

Please include any radiographs which may help in evaluating the patient. We will return them to you after use. Digital images may be emailed to jgriffin@cornerstonedental.com

Type of Referral

- Patient new to your practice
- Regular attender

Reason for Referral

- Oral Sedation
- IV Sedation

Has the patient had sedation before? Yes No

If Yes, when and where? _____

Were there any problems encountered? (Please specify) _____

Procedure Required

(Please Specify): _____
