Special Smiles LTD.

Comprehensive dental care for persons with special needs

LETTER OF NECESSITY FOR DENTAL TREATMENT UNDER GENERAL ANESTHESIA

Date: _____

Patient Name: _____

DOB: _____

Patient Diagnosis (Please check all that apply):

❑ **Intellectual Disability** ❑ **Autistic** ❑ **Anxiety** ❑ **CP** ❑ **Down Syndrome** ❑ **MS**

❑ **Other:** _____

Please be advised that the above-named patient is being referred to Special Smiles for dental treatment under General Anesthesia in an out-patient setting due to his/her inability to be treated in a regular dental setting.

Should you have any questions feel free to contact my office for assistance.

Referring Doctor (Print): _____

Address: _____

_____

_____

Phone: _____

Fax: _____

Email: _____

Referring Doctor Signature: _____

Please return this form to Special Smiles via fax or email.

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