Special Smiles
Comprehensive dental care for persons with special needs

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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: _____

IMPORTANT INFORMATION: When referring a "new patient" to Special Smiles please be sure to have the caregiver/guardian take a copy of the referral form with them. This form is required when they complete our "New Patient Intake/Health History" form on-line at www.specialsmilesltd.com. Referrals should not be sent directly to Special Smiles for new patients.