



Dr. J. Bhalla, B.D.S., MSc.
Dental Anaesthesiologist

SEDATION REFERRAL FORM

Patient Name: _____

Age: _____

Referral for Pre Treatment Consultation

Referral for Complete Treatment

Referral for Specific Treatment

Remarks / Treatment Instructions

Referring Doctor: _____

Phone: _____

Address: _____

Postal Code: _____

