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|  | **GENERAL ANESTHESIA DENTISTRY OF MICHIGAN****REFERRAL FORM** |

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| Patient Name/Age: |
| Guardian Name/Phone: |
| Dental Concerns: |
|  |
| Reason for Needing General Anesthesia: |
| Referring Doctor’s Name/Phone: |
| Date of Referral: |
| OUR OFFICE INFORMATION |
| Office Phone: 248-704-1357 Contact: Kim or Ashlei |
| \*\* Please leave voicemail or text if we happen to be unavailable. We will contact you promptly. |
| Office Email: info@GeneralAnesthesiaDentistryMichigan.com |
| Office Address: 18800 W 10 Mile Rd. Southfield, MI 48075 |
| Office Website: www.GeneralAnesthesiaDentistryMichigan.com |
| Office Hours: Monday – Thursday: 8 am – 6 pm. Friday – Saturday: 8 am – 2 pm. |

