Dental Services
Health Department
Iqaluit, Nu
X0A 0H0
PH: (867) 975-8600 ext 6206/ 6207
Fax: (867) 975-8620

Nunavut

General Anaesthetic Referral

Referral Date (DD/MM/YY):______/______/______ **Community:**______________________

Clients Surname:______________________ **Given Name:**______________________

HCP#:______________________ **DOB** (DD/MM/YY):______/______/______

Parent/Guardian Name:____

Contact Info: (Home)______________________ (Work)______________________

(Cell)______________________ (Other)______________________

Does the client have medical condition that may place him/her at risk for treatment under GA?
YES / NO
If yes, please explain:____

____

Has client previously been seen under GA for dental treatment? **YES / NO**
If yes, When?____

Client's Current Dental Status:

Significant Pain ☐ Tooth #:______________________
Evidence of Infection ☐ Tooth #:______________________
Has client been placed on antibiotics? Please list:______________________

Are you able to do a complete exam? **YES / NO**

Treatment Plan: Please indicate the treatment for each tooth using the following legend.
Please include all available radiographs.

X = extraction, **P** = pulpotomy, **R**= restorable with direct material or stainless steel crown

55	54	53	52	51	61	62	63	64	65
85	84	83	82	81	71	72	73	74	75

18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28
48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38

Please indicate reason for GA referral (ie. Age, lack of cooperation, extent of disease, etc).

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____

Referring Dental Provider:______________________ **Signature:**______________________

(Please Print Clearly)