

Sedation Referral Form



Please complete this form in **BLOCK CAPITALS** in ink.

Date: / /

Type of Referral: Independent NHS Urgent Routine

Has the patient been to the practice before? Yes No

Perfect Smile Reading
(formerly Reading Dental Sedation Clinic)
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PERSONAL DETAILS

Title e.g. Mr/Mrs/Ms:	<input type="text"/>	Date of Birth:	<input type="text" value="D"/> <input type="text" value="D"/> / <input type="text" value="M"/> <input type="text" value="M"/> / <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>
First Name:	<input type="text"/>	Surname:	<input type="text"/>
Email:	<input type="text"/>		
Telephone Number:	<input type="text"/>	Mobile Telephone Number:	<input type="text"/>
Address:	<input type="text"/>		
Town:	<input type="text"/>	Postcode:	<input type="text"/>
Main Occupation:	<input type="text"/>		

TREATMENT REQUIRED

Conservation:

<input type="text"/>

Reason for referral
(Please give as much information as possible)

<input type="text"/>

Extractions (please specify if surgical):

<input type="text"/>

Other Treatment:
(i.e Invisalign, Dental Implants, Periodontics, Endodontics, or Cosmetic Treatments)

<input type="text"/>

MEDICAL CONDITIONS

<input type="checkbox"/> Cardiac Problems (Angina, Murmur, other Heart Problem)	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Allergies (Please specify)
<input type="checkbox"/> Rheumatic Fever/Chorea	<input type="checkbox"/> Bleeding/Clotting Problems	
<input type="checkbox"/> Respiratory Problems	<input type="checkbox"/> Sickle Cell Status	<input type="checkbox"/> Any Other Relevant Information/Medication
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Sedation Required	

Please Note: Any relevant X-rays must be sent with this referral form along with the patients latest Medical History Form

Practice Name:	<input type="text"/>
Referring Dentist Name:	<input type="text"/>
Address:	<input type="text"/>
Telephone Number:	<input type="text"/>
Signature:	<input type="text"/>

Practice Stamp:

<input type="text"/>
