

Sedation Referral Form



Please complete this form in BLOCK CAPITALS in ink.

Date: / /

Type of Referral:
Independent NHS Urgent Routine

Patient Weight: kg / stone
Patient Height: cm / ft inch
BMI:

Has the patient been to the practice before? Yes No

PERSONAL DETAILS

Title e.g. Mr/Mrs/Ms: Date of Birth: / /

First Name: Surname:

Email:

Telephone Number: Mobile Telephone Number:

Address:

Town: Postcode:

Main Occupation:

TREATMENT REQUIRED

Last Dental Visit: / /

Oral Hygiene: Poor Good Excellent

Conservation:
(Surfaces of teeth)

<input type="text"/>	<input type="text"/>
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Reason for referral
(Please give as much information as possible)

Extractions (please specify if surgical):

<input type="text"/>	<input type="text"/>
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Have you provided treatment before this referral?
 Yes No

What treatment have you attempted?

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 from your practice

Practice Name:

Referring Dentist Name:

Address: Telephone Number:

Signature:

Practice Stamp:

Anxiety Questionnaire

TO BE COMPLETED BY PATIENTS WHO MAY REQUIRE SEDATION



Full Name: _____

Date: _____

Can you tell us how anxious you get, if at all, when you need to see the dentist? Please indicate by putting an 'X' in the appropriate boxes below.

1. IF YOU WERE GOING TO YOUR DENTIST FOR TREATMENT TOMORROW, HOW WOULD YOU FEEL?

NOT ANXIOUS SLIGHTLY ANXIOUS FAIRLY ANXIOUS VERY ANXIOUS EXTREMELY ANXIOUS

2. IF YOU WERE ABOUT TO HAVE A TOOTH FILLED INVOLVING DRILLING, HOW WOULD YOU FEEL?

NOT ANXIOUS SLIGHTLY ANXIOUS FAIRLY ANXIOUS VERY ANXIOUS EXTREMELY ANXIOUS

3. IF YOU WERE ABOUT TO HAVE A TOOTH EXTRACTED, HOW WOULD YOU FEEL?

NOT ANXIOUS SLIGHTLY ANXIOUS FAIRLY ANXIOUS VERY ANXIOUS EXTREMELY ANXIOUS

4. IF YOU WERE ABOUT TO HAVE YOUR TEETH SCALED & POLISHED, HOW WOULD YOU FEEL?

NOT ANXIOUS SLIGHTLY ANXIOUS FAIRLY ANXIOUS VERY ANXIOUS EXTREMELY ANXIOUS

5. IF YOU WERE ABOUT TO HAVE AN INJECTION IN YOUR GUM, HOW WOULD YOU FEEL?

NOT ANXIOUS SLIGHTLY ANXIOUS FAIRLY ANXIOUS VERY ANXIOUS EXTREMELY ANXIOUS

DENTIST TO SCORE ANXIETY QUESTIONNAIRE

Each of the five answers is scored as follows:

NOT ANXIOUS = 1
SLIGHTLY ANXIOUS = 2
FAIRLY ANXIOUS = 3
VERY ANXIOUS = 4
EXTREMELY ANXIOUS = 5

SCORE IS A SUM OF ALL FIVE ITEMS (RANGE 5-25)