

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: