SEDATION REFERRAL FORM

TODAY's Date: .....

REFERRING Dentist: .....

PATIENT DETAILS :

First Name and Surname: .....

Date of Birth .....
Address:.....
....

Postcode: .....

Telephone No's: Home:.....

Mobile: ..... Preferred Contact No: .....
Work: .....

PLEASE CIRCLE REASON FOR REFERRAL: Anxiety /Phobia, Gag Reflex, Failed LA, Surgical Procedure Please give details about or any medical information which might affect the provision of treatment:
.....
.....
.....
.....

Patient's ASA classification: _____ BMI ≤ 35 BMI at time of referral ( )

Patient's OH status: Satisfactory Poor

Relevant diagnostic Grade Acceptable radiographs must be provided (Preferably digital/email) (Tooth notation / surfaces of fillings clearly marked / diagnoses justifying treatment must be included)

Teeth to be conserved ----------/----------

Teeth for removal ----------/----------

Other Treatment ----------

Cosmetic restorative / periodontal therapies / definitive endodontic treatment / implants to be referred to our private practice only

Please ensure that the patient /parents/ guardian understand a consultation appointment is mandatory to obtain valid consent before sedation/treatment can be prescribed.

REFERRAL DENTIST'S/PRACTICE DETAILS

Practice: .....

Telephone No: .....

E-mail: .....