

# DENTAL SEDATION REFERRAL FORM Urgent

**Please complete all sections of these forms and retain a copy for your records. Incomplete referrals will be returned.**

# Routine



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| **PATIENT DETAILS From:**Full name: …………………………………………………………….……………………..……… **Referring Dentist:**Parent / Guardian: ………………………………………….……………………..…………… Name & Address Practice Clinic ……………………………………………………………………….… Date of birth: ……………………………………………………….………………………….…. …………………………………………………………………...…………………………………………………….. Mobile tel. no.: ……………………………………………….……………………….…………. Tel. no. .………………………………………………………………………………………………..………….. Daytime tel. no.: ………………………………………………….……………………………… Fax no. .……………………………………………………………………………………………….…………… Parent’s/Patients’ address: Email: …………………………………………………………………………………………………………..…..………………………………………………………………………………….………..…………….…. Signature: ………………………………………………………………………………………………………..…………………………………………………………………………………….………………………. Date: ………………………………………………………………………………………………………….……**PATIENT’S MEDICAL PRACTICTIONER**GP: ……………………………………………………………………………………..…………..……. GP Practice: ………………………………………………………………………………..…………………… Tel. no.: …………………………………………………………………………………….……….…. Fax no: …………………………………………………………………………………………………………….. |
| **JUSTIFICATION FOR REFERRAL (tick all that apply)**Anxiety Lack of co-operation Needle phobic Prolonged or unpleasant treatment Pronounced gag reflex Other please state ……………………………………………………. | Please state patient’s:Height ……………………Weight …………………..BMI …………………. |
| **RELEVANT MEDICAL HISTORY** – please give details of any medical conditions and medication |
| **DETAILS OF PREVIOUS DENTAL TREATMENT / ONGOING DENTAL TREATMENT /PREVIOUS SEDATION/PREVIOUS GENERAL ANAESTHETIC** |
| **TREATMENT REQUESTED (Dental Notation)**Please tick all that apply:Conservation Suitable for single drug IV sedation Extraction Please indicate if you are happy for us to carry out any other necessary treatmentwithout contacting you prior to treatmentAny other treatment  |
| **PRE-REFERRAL CHECKLIST** – please tick to confirm you have checked the following:Patient is over the age of 18 YES  NO Patient is ASA 1 or ASA II YES  NO Patient has a BMI < 35 YES  NO  Is patient is pregnant and in pain? YES  NO  *If Yes, patient cannot be sedated here – please refer to CDS*Have you discussed the nature of the referral with the patient? YES  NO Have you discussed the risks associated with the sedation? YES  NO  Has the patient understood and consented to the referral? YES  NO  Radiographs attached? YES  NO Orthodontic treatment plan letter attached? YES  NO  Delivering Better Oral Health prevention programme implemented? YES  NO  |

**Please use this page for any further information you wish to include with your referral**