

# 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 treatment  without contacting you prior to treatment  Any 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**