Sedation Referral Form

Please complete this form in BLOCK CAPITALS in ink.

Date: D D / M M / Y Y Y Y

Type of Referral:
Independent ☐ NHS ☐ Urgent ☐ Routine ☐

Has the patient been to the practice before? Yes ☐ No ☐

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

PERSONAL DETAILS

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

First Name: Surname:

Email:

Telephone Number: Mobile Telephone Number:

Address:

Town: Postcode:

Main Occupation:

TREATMENT REQUIRED

Last Dental Visit: D D / M M / Y Y Y Y

Oral Hygiene: ☐ Poor ☐ Good ☐ Excellent

Conservation:
(Surfaces of teeth)



Reason for referral
(Please give as much information as possible)

Extractions (please specify if surgical):



Have you provided treatment before this referral?
☐ Yes ☐ No

What treatment have you attempted?

MEDICAL CONDITIONS

☐ Cardiac Problems (Angina, Murmur, other Heart Problem)	☐ Epilepsy	☐ Allergies (Please specify)
☐ Rheumatic Fever/Chorea	☐ Bleeding/Clotting Problems	
☐ Respiratory Problems	☐ Stickle Cell Status	☐ Any Other Relevant Information/Medication
☐ Diabetes	☐ 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: