LONDON ROAD
DENTAL PRACTICE
Healthy teeth, happier smile!

DENTAL SEDATION REFERRAL FORM

PATIENT DETAILS

Title & Full name: ______________________________

Date of birth: _________________________________

Mobile tel. no.: _______________________________

Daytime tel. no.: ______________________________

Home address: _________________________________

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PATIENT'S DOCTOR

GP practice: __________________________________

Tel. no.: _____________________________________

REFERRING DENTIST

Name: _______________________________________

Practice: _____________________________________

Address: _____________________________________

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Tel. no.: _____________________________________

Email: _______________________________________

Is patient in pain? YES ☐ NO ☐

Signature: ____________________________________

Date: ____

JUSTIFICATION FOR REFERRAL (tick all that apply)

Anxiety ☐

Lack of cooperation ☐

Needle phobic ☐

Prolonged or unpleasant treatment ☐

Increased gag reflex ☐

Other (please state) __________________________

RELEVANT MEDICAL HISTORY – Please give details of any medical conditions and medication

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DETAILS, IF ANY, OF ANY PREVIOUS SEDATION / GENERAL ANAESTHETIC:

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TREATMENT REQUIRED:

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