

Healthy teeth, happier smile!

DENTAL SEDATION REFERRAL FORM

PATIENT DETAILS	REFERRING DENTIST
Title & Full name:	Name:
Date of birth:	Practice:
Mobile tel. no.:	Address:
Daytime tel. no.:	
Home address:	
	Tel. no.:
	Email:
PATIENT'S DOCTOR	Is patient in pain? YES NO
GP practice:	Signature:
Tel. no.:	Date:
Prolonged or unpleasant treatment Increased gag reflex Other (please state)	
RELEVANT MEDICAL HISTORY – Please give de	etails of any medical conditions and medication
DETAILS, IF ANY, OF ANY PREVIOUS SEDATIO	N / GENERAL ANAESTHETIC:
TREATMENT REQUIRED:	