



**LONDON ROAD
DENTAL**

DENTAL SEDATION REFERRAL FORM

PATIENT DETAILS

Title & Full name: _____

Date of birth: _____

Mobile tel. no.: _____

Daytime tel. no.: _____

Home address: _____

REFERRING DENTIST

Name: _____

Practice: _____

Address: _____

Tel. no.: _____

Email: _____

PATIENT'S DOCTOR

GP practice: _____

Tel. no.: _____

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

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

TREATMENT REQUIRED:
