

Sedation Referral Form

REFERRAL FORM (18 years old +)

Patient details			
Patient name		GP name and Address (if known)	
Address			
D.O.B.		GP Tel no	
Ethnic origin		NHS Number	
NHS or Private	NHS Private	Gender	Male Female
Contact number(s)		Special care requirements (wheelchair user, translation services)	
Referring dentist			
Dentists name		Tel no	
Practice address		e-mail	
Referral			
<u>Justification (tick all that apply)</u> Anxiety Lack of co-operation Needle phobic Prolonged or unpleasant treatment Increased gag reflex Possible Surgical Extraction Multiple Extractions Other – please state		Please state modified dental anxiety score (MDAS):	
Details of relevant previous dental/sedation treatment, ongoing dental treatment and previous general anaesthetic:			
Relevant Medical History:			
NHS patients: This treatment is part of a NHS banded course evidenced by the attached FP17RN Yes No			
Relevant radiographs enclosed: Yes No (please enter qty by each type)			

OPG	Bitewings	Periapical	Other
Treatment required			
INTRAVENOUS SEDATION			
Extractions .			
N.B We are able to accept some restorative treatment through private referrals			
<u>Pre-referral checklist</u>			
Patient is ASA 1 or ASA II		Yes/No	
Patient BMI >18 and <35 (use BMI chart)		Yes/No	
Is patient pregnant?		Yes/No	
Have you discussed the risks associated with sedation?		Yes/No	
Patient does not use recreational drugs		Yes/No	
<u>Declaration</u>			
I have attempted treatment on this patient, date(s) attempted_____.			
I have discussed all alternative methods of pain and anxiety control. I am happy for you to carry out any other necessary treatment that is identified on the day. (Note, the clinic will make every attempt to contact you to inform/discuss any change to the treatment plan before carrying out the treatment.)			
Dentists signature_____		Date _____	
GDC Number: _____			

Send referrals to sharrow.dentalsurgery.nhs.net