LOVE THE DENTIST

sedation referral form

Referral Form

PATIENT DETAILS REFERRING DENTIST

Title & Full name

Date of birth

Mobile tel. no.

Daytime tel. no.

Home address

REFERRING DENTIST

Name

Practice

Address

Tel. no

Email

Is the patient in pain? ☐ Yes ☐ No

PATIENT'S DOCTOR

GP practice

Tel. no.

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: