REFERRAL FOR DENTISTRY WITH CONSCIOUS SEDATION

NHS	☐	PRIVATE	☐
URGENT	☐	ROUTINE	☐

PATIENT DETAILS

TITLE
FIRST NAME:
LAST NAME:
DATE OF BIRTH: AGE:
ADDRESS:
POSTCODE:
NHS NUMBER:
DAYTIME TEL:
MOBILE TEL:
EVENING TEL:
E-MAIL:
PARENT/CARER/SUPPORT WORKER NAME AND CONTACT DETAILS (WHERE APPROPRIATE):
GMP NAME & ADDRESS:

REFERRER DETAILS

REFERRING DENTIST:
PRACTICE NAME:
PRACTICE ADDRESS:
POSTCODE:
PRACTICE E-MAIL:
PRACTICE TEL:
PRACTICE FAX NO:

JUSTIFICATION FOR SEDATION (PLEASE TICK ALL THAT APPLY)

ANXIETY	☐	LACK OF CO-OPERATION	☐
NEEDLE PHOBIC	☐	PROLONGED OR UNPLEASANT TREATMENT	☐
INCREASED GAG REFLEX	☐		

OTHER PLEASE STATE

COMMENT (IF ANY)

REFERRAL DETAILS

TREATMENT REQUIRED	
APPROPRIATE RADIOGRAPHS	ATTACHED ☐ SENT ELECTRONICALLY ☐
RELEVANT CLINICAL DETAIL INCLUDING DETAILS OF ANY TREATMENT ATTEMPTED AND PREVIOUS EXPERIENCE OF SEDATION/GA	
MEDICAL HISTORY INCLUDING CURRENT MEDICATIONS	
ARE THERE ANY COMMUNICATION ISSUES?	
ARE THERE ANY MOBILITY ISSUES?	

PRE-REFERRAL CHECKLIST – PLEASE TICK TO CONFIRM YOU HAVE CHECKED THE FOLLOWING:

PATIENT IS OVER THE AGE OF 3	YES ☐	NO ☐
PATIENT IS ASA 1 OR ASA II OR STABLE ASA III	YES ☐	NO ☐
PATIENT HAS A BMI > 18 AND < 35	YES ☐	NO ☐
IS PATIENT PREGNANT BUT IN PAIN?	YES ☐	NO ☐
HAVE YOU DISCUSSED THE NATURE OF THE REFERRAL WITH THE PATIENT?	YES ☐	NO ☐
HAVE YOU DISCUSSED THE OPTIONS BENEFITS AND RISKS ASSOCIATED WITH THE SEDATION?	YES ☐	NO ☐
HAS THE PATIENT/THOSE WITH PARENTAL RESPONSIBILITY CONSENTED TO THE REFERRAL?	YES ☐	NO ☐
RELEVANT RADIOGRAPHS ATTACHED OR SENT ELECTRONICALLY?	YES ☐	NO ☐
ORTHODONTIC TREATMENT PLAN LETTER ATTACHED (WHERE APPROPRIATE)?	YES ☐	NO ☐
ORAL HEALTHCARE PREVENTION PROGRAMME IMPLEMENTED?	YES ☐	NO ☐
THE PATIENT MEETS THE REFERRAL CRITERIA AS OUTLINED IN OUR REFERRAL PROTOCOLS?	YES ☐	NO ☐

SIGNATURE OF REFERRING CLINICIAN:	DATE:

PLEASE SEND ALL REFERRALS TO:

"NAME"
"CLINIC"
"ADDRESS 1"
"ADDRESS 2"
"CITY"
"POSTCODE"

REFERALLS@CLINIC.CO.UK

ENCLOSURES / ATTACHMENTS:

MEDICAL HISTORY ☐ RADIOGRAPHS ☐ ORTHODONTIC TREATMENT PLAN ☐