

SEDATION REFERRAL FORM

PLEASE PRINT CLEARLY IN CAPITALS

PATIENT DETAILS

Has patient been referred here before Yes No

Mr. Mrs. Miss Ms. Master

Tel. (home)

Surname

Mobile

Forenames

Occupation

Date of Birth

Sex:(please tick) Male Female

Address

Next of Kin details

TREATMENT REQUIRED

NHS PRIVATE

PLEASE SPECIFY

LA& SEDATION

URGENT

Extractions

Conservation

Other Treatment

Please use this space to give further details on above if necessary

OTHER INFORMATION

REASONS FOR REFERRAL

Nervous/un-cooperative patient

Phobic

Difficulty with local anaesthesia

Other, please specify

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REFERRING DENTIST

I understand that the decision as to whether the treatment will be provided using sedation, will be taken by the treating Dentist and Anaesthetist.

Explained the risk involved

Minor Risk- These may include damage to teeth, stiff neck, headache, nausea & vomiting.

SIGNATURE

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PRINT NAME:

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DATE:

--

REFERRED BY:

<h1>STAMP HERE</h1>

Telephone No.

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PLEASE RETAIN BOTTOM COPY
FOR YOR RECORDS

CONFIDENTIAL MEDICAL HISTORY QUESTIONNAIRE

It is important that you complete this questionnaire as fully and correctly as possible, so that we may ensure that the operation and anaesthesia are adopted appropriately.

PLEASE CIRCLE YOUR ANSWER

Have you had a cold, cough or temperature during the past 7 days. YES/NO

Do you suffer from or have you had any of the following

Heart attack/Angina/-strokes/Chest pain	YES/NO
Heart "Murmurs"/Heart operations	YES/NO
Rheumatic fever	YES/NO
Lung operations/Shortness of breath	YES/NO
Diabetes	YES/NO
Epilepsy/Fits/Blackouts	YES/NO
Muscle or Nerve disorders (multiple Sclerosis. Myopathy etc.)	YES/NO
Bleeding disorder/Haemophilia/Anticoagulants	YES/NO
Ladies, are you PREGNANT	YES/NO

If you have answered YES to any of the above questions this may mean that we are unable to give you an anaesthetic as an Out-Patient. Please contact the Clinic now.

In addition, do you suffer from or have you had any of these problems

Jaundice/Hepatitis/Liver disease	YES/NO
Kidney disease	YES/NO
Asthma/Bronchitis/TB	YES/NO
High Blood Pressure	YES/NO
Stomach/Bowel disorders, including ulcers	YES/NO
Pacemaker	YES/NO
Any previous operations	YES/NO

Are you ALLERGIC to anything

If YES, please list here: _____

Are you taking any tablets, Inhalers. Medicines or Injections (including the Pill) YES/NO

Have you had Sedation before

If YES, please tell us when was the last one: Months/Years ago

Have you or anyone in you family had a reaction or complications to any sort of anaesthetic YES/NO

Do you suffer from Sickle Cell Anaemia- Does anyone in your family YES/NO/NOT TESTED

Do you smoke YES/NO

How much alcohol do you drink in a week

Are you wearing

Full or partial Dentures/Crowns/Bridgework/Braces YES/NO

Contact Lenses YES/NO

I certify that all of the above information is, to the best of my knowledge true.

Signature: _____ **Date:** _____

(of the PATIENT/PARENT/GUARDIAN)