Conscious Sedation Referral Form For Private Patients

CRAIGENTINNY DENTAL CARE

Patient Details

Name:		Date of birth:	
Address:			
		Telephone (main):	
		Telephone (mobile):	
Postcode:		E-mail:	

Referral Reason

☐ Anxiety ☐ Invasive Procedure ☐ Co-operation ☐ Other (please specify)

Treatment Requested

Restoration

Preferred Material ☐ amalgam ☐ composite

Additional Information

Extractions

☐ Other – please specify

Radiographs Enclosed

☐ Bitewings ☐ Periapical ☐ OPT ☐ Other

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JOHN BOOTH BDS MFGDP FRASER HENDRIE BDS MFGD MARTIN MORLEY BDS LDS

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Relevant Medical and Dental History – please provide a full list of medical conditions and medications

Referral Checklist

- ☐ The patient is over the age of 18
- ☐ The patient weighs less than 150Kg
- ☐ The patient meets the ASA Physical Status 1[*1] or ASA Physical Status 2[*2] criteria
- ☐ The patient is aware they are being referred for Sedation and that no treatment is usually carried out on the first visit.
- ☐ If the referral is for orthodontic extractions, I have enclosed a copy of the specialists treatment plan and relevant radiographs

[*1]ASA Physical Status 1 – A normal healthy patient
[*2]ASA Physical Status 2 – A person with mild systemic disease

Referring Dentist Details

Name:	E-mail :
Address:	Telephone (main):
	Signed:
Postcode:	Date:

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