



REFERRING DENTIST

NAME	_____	DATE	_____
ADDRESS	_____	TEL	_____
	_____	FAX	_____
	_____ POST CODE _____	EMAIL	_____

PATIENT DETAILS

NAME	_____	HOME	_____
ADDRESS	_____	WORK	_____
	_____	MOB	_____
	_____ POST CODE _____	DOB	_____

RELEVANT MEDICAL HISTORY

PLEASE INCLUDE ANY RADIOGRAPHS WHICH MAY HELP IN EVALUATING THE PATIENT. WE WILL RETURN THEM TO YOU AFTER USE.

TYPE OF REFERRAL (PLEASE TICK)

- PATIENT NEW TO YOUR PRACTICE
- REGULAR ATTENDER

REASON FOR REFERRAL

- ORAL SEDATION (TEMAZEPAM)
- IV SEDATION (MIDAZOLAM)

HAS THE PATIENT HAD SEDATION BEFORE? YES NO

IF YES, WHEN AND WHERE? _____

WERE THERE ANY PROBLEMS ENCOUNTERED? (PLEASE SPECIFY) _____

PROCEDURE REQUIRED

(PLEASE SPECIFY): _____

