St Faith
DENTAL CLINIC

REFERRAL FORM

Patient Details:

Name _____ Date of Birth _____

Address _____

_____ Post Code _____

Tel: Home _____ Work _____ Mobile _____

Email Address: _____

Relevant Xrays Included - Yes ☐ No ☐

Can your appointment be sent by email: Yes ☐ No ☐

TREATMENT REQUIRED

	Right	Left
Teeth to be extracted		
Teeth to be filled		
Other Treatment (Please Specify)		
Dental Implants		

Referring Dentist: Name .....

Practice Stamp:

Signature:.....Tel:.....

CONFIDENTIAL MEDICAL HISTORY QUESTIONNAIRE

Yes	No	
☐	☐	Angina / High Blood Pressure / Rheumatic Fever / Other Heart Disease
☐	☐	Asthma / Bronchitis / Other Chest Disease
☐	☐	Do you have any form of Mental or Physical Handicap
☐	☐	Do you have an autism spectrum disorder?
☐	☐	Fits / Convulsions / Blackouts / Epilepsy
☐	☐	Hepatitis / HIV + / Jaundice / Liver / Kidney Disease
☐	☐	Diabetes / Ulcers or serious indigestion
☐	☐	Muscle Problems / Myopathy / Paralysis / Nerve Disease
☐	☐	Bruise Easily / Abnormal Bleeding / Anaemia / Sickle Cell / Thrombosis
☐	☐	Allergies / Reactions to drugs or previous anaesthetics
☐	☐	Have you had a general anaesthetic in the last 12 months?
☐	☐	Have you or anyone in your family had a reaction to an anaesthetic?
☐	☐	Do you have a joint replacement / Pacemaker / Implant?
☐	☐	Are you pregnant?
☐	☐	Do you smoke?
☐	☐	Are you taking any medication? (tablets, inhalers, injections or others)
☐	☐	Any other medical condition or previous hospital admissions?
☐		How many units of alcohol do you drink per week?
☐		How tall are you?
☐		What is your weight?

If there is anything you do not understand please ask your dentist.

If you answered yes to any question above, please give details below:

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.....

Name of General Practitioner:.....

Address:.....

.....Tel:.....

REFERRING DENTIST:

I confirm that I have discussed alternative treatment options and the risks associated with conscious sedation and this patient has agreed to be referred to you for treatment. I understand that the type of conscious sedation given will be decided with the sedationist and treating dentist.

Signed……Date……

My patient would like to attend a pre-assessment clinic ☐