Referrals for treatment requiring sedation, dental implants and complex surgical procedures.

An on-line version of this form and other resources can be found at *www.arnicadentalcare.co.uk/referral-service*

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PATIENT REFERRAL FORM

PATIENT DETAILS

First Name ______________________ Title ______________________

Surname ______________________

Date of Birth ______________________

Telephone (Home) ______________________

Telephone (Work) ______________________ Email ______________________

Address ______________________

____

____

TREATMENT REQUIRED: *(Please Tick)*

☐ Restorative

☐ Extractions

☐ Implants

☐ Other (please specify)

Anxiety Score (1 = calm, 10 = phobic) ______________________ Regular Attendee? Yes ☐ No ☐

Radiographs Enclosed? Yes ☐ No ☐ If yes, please specify: ______________________

FURTHER INFORMATION:

____

____

Please complete reverse

Referrals for treatment requiring sedation, dental implants and complex surgical procedures.

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MEDICAL QUESTIONNAIRE

HAS THE PATIENT EVER HAD OR DOES THE PATIENT SUFFER FROM: *(Please Tick)*

- *Heart Trouble* ☐
- *Heart murmur/rheumatic fever* ☐
- *Chest Trouble* ☐
- *Bleeding tendencies* ☐
- *High blood pressure* ☐
- *Asthma* ☐
- *Liver disease* ☐
- *Stroke* ☐
- *Kidney disease* ☐
- *Diabetes* ☐
- *Epilepsy/convulsions* ☐
- *Anaemia* ☐

Please provide details as appropriate

IS THE PATIENT TAKING ANY MEDICATIONS OR DRUGS? *(Please Tick)*

Yes ☐ No ☐ If yes, please specify

IS THE PATIENT ALLERGIC TO ANYTHING? *(Please Tick)*

Yes ☐ No ☐ If yes, please specify

HAS THE PATIENT EVER HAD SEDATION FOR DENTAL TREATMENT *(Please Tick)*

Yes ☐ No ☐ If yes, were any problems encountered?

IS THE PATIENT PREGNANT *(Please Tick)*

Yes ☐ No ☐ Date due

REFERRED BY:

Dentist

Practice

Telephone Email

Address

Signature Date