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-resources*

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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

73 Leckhampton Road, Cheltenham, Gloucestershire GL53 0BS t 01242 655554 www.arnicadentalcare.co.uk

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MEDICAL QUESTIONNAIRE

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

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

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