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LHDP
REFERRAL CENTRE

# sedation referral form

## Practice Details

Referring Practice: Date Referred:

Referring Dentist:

Practice Address:

Postcode:

## Patient Details

☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Other Patient's Name:

Patient's Address

Telephone Numbers: Home: Work: Mobile:

Email:

Date of Birth: Is this referral urgent? ☐ Yes ☐ No

## Reason for Referral

- ☐ Routine extraction
- ☐ Restoration treatment
- ☐ Endodontic treatment
- ☐ Implant treatment
- ☐ Oral surgery treatment
- ☐ Anxiety
- ☐ Gag reflex
- ☐ Other routine treatment - Please specify
- ☐ Other non-routine treatment - Please specify
- ☐ Other - Please specify

## Brief History / Comments about this Referral

## Dental / Medical History

Is the patient taking any medication? If so please list below:

We see all our patients initially for a pre-sedation assessment - please tick to confirm the patient has been advised of the need for this initial appointment prior to any treatment ❑

*Please enclose any xrays

**Thank you for your valued referral**