



TORRINGTON DENTAL
PRACTICE

Torrington Dental Practice Sedation Referral Form

Please complete this form for sedation referrals only

IMPORTANT INFORMATION

ANY SUBMISSIONS WITHOUT ALL THREE SECTIONS BEING SUBMITTED TOGETHER
WILL BE REJECTED

Referral Information

Referral date

DD-MM-YYYY



Date

Dentist *

Practice *

Address

Street Address

Street Address Line 2

Town

County

Postal Code

Dentist Email *

Patient Information

Patient Name *

First Name

Last Name

Parents/Guardian (if applicable)

First Name

Last Name

Address *

Street Address

Street Address Line 2

Town

County

Postal Code

Patient Email *

Gender *

Male

Female

Date of birth *

Phone contact details

Home number:

Mobile number:

Work number:

Are you happy to be contacted via telephone or email (or both). Please tick to confirm which.

Phone

Email

Occupation

Sedation details

Dental service *

Private

NHS

Which type of sedation is required? *

IV sedation

Inhalation sedation

Please detail treatment required

Type here...



Any special dental or medical factors, such as known allergies or unusual medical treatments, should be noted.

History of symptoms/treatment tried

Type here...



Any special dental or medical factors, such as known allergies or unusual medical treatments, should be noted.

Please upload attachments below. If attachments are not uploaded, please state the reason why.

Type here...



Any special dental or medical factors, such as known allergies or unusual medical treatments, should be noted.

Relevant radiographs



Browse Files

Drag and drop files here

TDP Medical history



Browse Files

Drag and drop files here

FP17DN



Browse Files

Drag and drop files here



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SEDATION TEAM

CONFIDENTIAL MEDICAL HISTORY

Please complete this section so that we can provide you with safe and comfortable treatment.

It is important to include all information requested. If you withhold information, you may put yourself at unnecessary risk.

Please use the additional space after each question to provide any more details.

PERSONAL INFORMATION

TO BE COMPLETED BY THE PATIENT

Patient Name *

First Name

Last Name

DENTAL AND MEDICAL HISTORY

Name of last dentist: *

When did you last receive dental treatment? *

Doctors name: *

Doctors surgery: *

Doctors phone number:

How would you rate your general health? *

- Excellent
- Good
- Fair
- Poor

Have there been any recent changes in your health? *

- Yes
- No

If yes, please provide details:

MEDICATIONS

Please list any medications you are currently taking, including any prescribed, herbal or recreational medications

SEDATION HISTORY

Have you ever had sedation for any procedure? *

- Yes
- No

If yes, please tick which types:

- Tablet
- Gas and air
- Injection in hand/arm
- Other

If yes, what was this for?

Have you ever had a general anaesthetic? *

Yes

No

If yes, what was this for?

Is there any family history of problems with sedation? If yes, please detail:

HEART

Have you ever had any of the following:

Heart attack *

Yes

No

High blood pressure *

Yes

No

Chest pains/palpitations *

Yes

No

Angina *

Yes

No

Stroke *

Yes

No

Rheumatic fever *

Yes

No

Pacemaker/heart surgery *

Yes

No

Heart murmur *

Yes

No

BLOOD

Have you ever had any of the following:

Anaemia *

Yes

No

Sickle cell disease *

Yes

No

Excessive bleeding/bruising after treatment or surgery *

Yes

No

Blood refused by the transfusion service *

Yes

No

Abnormal blood test results *

Yes

No

CHEST

Have you ever had any of the following:

Shortness of breath walking *

Yes

No

Shortness of breath lying down *

Yes

No

Bronchitis *

Yes

No

TB *

Yes

No

Asthma *

Yes

No

COPD/emphysema *

Yes

No

Cold/chest infection currently *

Yes

No

Cough regularly *

Yes

No

OTHER

Have you ever had any of the following:

Fainting/dizziness/blackouts *

Yes

No

Liver disease/jaundice *

Yes

No

Hepatitis *

Yes

No

Kidney disease *

Yes

No

Infectious disease e.g. HIV/CJD *

Yes

No

Gastric ulcer/hiatus hernia *

Yes

No

Diabetes *

Yes

No

Thyroid problems *

Yes

No

Arthritis *

Yes

No

Myasthenia gravis *

Yes

No

ALLERGIES

Do you have any allergies? *

Yes

No

Do you have asthma/eczema? *

Yes

No

Have you taken any steroid medication in the last two years? If yes, details:

SOCIAL HISTORY

Do you smoke? *

- Yes
 No

If yes, are you interested in giving up?

- Yes
 No

Do you take recreational drugs? *

- Yes
 No

How many units of alcohol do you drink a week? *

e.g., 23

Are you pregnant? *

Yes

No

Do you have children under 16? *

Yes

No

Do you care for anyone? *

Yes

No

Do you have sleep apnoea? *

Yes

No

Have you had eye surgery? *

Yes

No

Do you have any mental health problems? *

- Yes
- No

Should you have any additional information regarding the above answers, please enter it below.

Please complete the following questionnaire:

If you went to your dentist for TREATMENT TOMORROW how would you feel? *

- Not anxious
- Slightly anxious
- Fairly anxious
- Very anxious
- Extremely anxious

If you were sitting in the WAITING ROOM (waiting for treatment) how would you feel? *

- Not anxious
- Slightly anxious
- Fairly anxious
- Very anxious
- Extremely anxious

If you were about to have a TOOTH DRILLED, how would you feel? *

- Not anxious
- Slightly anxious
- Fairly anxious
- Very anxious
- Extremely anxious

If you were about to have your teeth SCALED AND POLISHED, how would you feel? *

- Not anxious
- Slightly anxious
- Fairly anxious
- Very anxious
- Extremely anxious


If you were about to have a LOCAL ANAESTHETIC INJECTION in your gum, how would you feel? *

- Not anxious
- Slightly anxious
- Fairly anxious
- Very anxious
- Extremely anxious

Please circle how you are feeling today:

■■■Loading...

Please sign and date (to be completed by the patients) *



Clear

Date

DD-MM-YYYY 



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DECLARATION FORM

Declaration by dentist

I can confirm that I discussed all treatment management options with the patient, including local anaesthetic only, inhalation, sedation, intravenous sedation and general anaesthetic.

The patient is aware of the differences and has requested treatment with conscious sedation.

Name *


First Name

Last Name

Date *

Dentist Signature *



Clear

Declaration by patient

I agree that the dentist has discussed the difference between conscious sedation and general anaesthetic, and I have requested treatment with conscious sedation.

Name *

First Name


Last Name

Date *

Patient Signature *





Clear

As a referral service, we reserve the right to return incomplete or inappropriate referral forms.

Referrers are advised that all referrals are subject to audit with respect to their quality and appropriateness.

Please verify that you are human *

I am human 
hCaptcha
Privacy - Terms

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