Harbour Dental

DENTAL SEDATION REFERRAL FORM

PATIENT DETAILS

TITLE: FORENAME:

DATE OF BIRTH: SURNAME:

ADDRESS:

POSTCODE:

MOBILE NUMBER: HOME NUMBER:

EMAIL ADDRESS:

RELEVANT MEDICAL HISTORY:

GP: TEL NO:

GP PRACTICE:

JUSTIFICATION FOR REFERRAL:
(Tick all that apply)

ANXIETY ☐

NEEDLE PHOBIC ☐

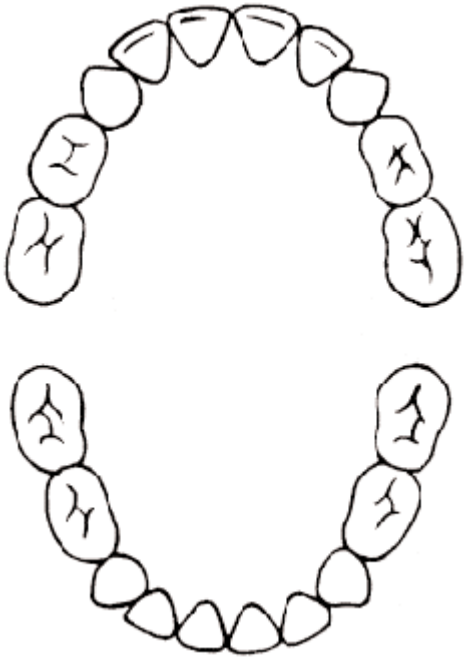
PRONOUNCED GAG REFLEX ☐

OTHER (Please state)

HAS THE PATIENT HAD SEDATION PREVIOUSLY?

23-25 CREWE ROAD, SANDBACH, CHESHIRE, CW11 4NE
INFO@HARBOURDENTALPRACTICE.CO.UK
01270 762 186

REQUESTED TREATMENT:



ADDITIONAL NOTES:

PLEASE RECORD THE ANXIETY LEVEL OF PATIENT

PLEASE STATE PATIENTS' HEIGHT: **FEET:** **INCHES:**

PLEASE STATE PATIENTS' WEIGHT: **STONE:** **POUNDS:**

PLEASE PROVIDE PATIENTS BMI:

REFERRER DETAILS

TITLE: FORENAME:

SURNAME:

PRACTICE ADDRESS:

CONTACT NUMBER: POSTCODE:

EMAIL ADDRESS:

PLEASE PROVIDE DETAILS OF IOSN.