Dr. Najeeb Hussain

SEDATION REFERRAL FORM

Morden Smiles

PRACTITIONER AND PRACTICE DETAILS:

Name of Practitioner

Practice Name

Address

Telephone

Email

PATIENT DETAILS:

Title **DOB**

Name

Address

Telephone

Email

MEDICAL HISTORY

TREATMENT REQUIRED

RESTORATION(S) (details):

EXTRACTION(S) (details):

OTHER TREATMENT: (details)

☐ **ADULT** ☐ **PAEDIATRIC**

URGENT? ☐ YES ☐ NO

REASON FOR REFERRAL:

☐ **ANXIETY** ☐ **NEEDLE-PHOBIA** ☐ **LA INEFFECTIVE** ☐ **PATIENT REQUEST** ☐ **OTHER (details):**

☐ **TREATMENT PLAN AGREED WITH PATIENT** ☐ **APPROPRIATE RADIOGRAPHS ENCLOSED**

Signed by Dentist:…… **Date:**……...

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