

QUEENSWAY

DENTAL PRACTICE

Sedation

QUEENSWAY CONSCIOUS SEDATION REFERRAL FORM

PATIENT DETAILS	
Name:	DOB:
Address:	Work Tel (W): Home Tel (H): Mobile Tel (M): Email (E):

NHS REFERRAL (Specify indication for sedation)	PRIVATE REFERRAL:
<input type="checkbox"/> Anxiety <input type="checkbox"/> Invasive procedure <input type="checkbox"/> Co-operation	<input type="checkbox"/> Anxiety <input type="checkbox"/> Invasive procedure <input type="checkbox"/> Co-operation <input type="checkbox"/> Other reason (please specify below);

TREATMENT REQUIRED	
Conservation:	
Extractions:	

RELEVANT RADIOGRAPHS ENCLOSED (please tick)
<input type="checkbox"/> DPT <input type="checkbox"/> Bitewings <input type="checkbox"/> Periapical

RELEVANT MEDICAL HISTORY/OTHER INFORMATION

REFERRING DENTIST DETAILS	
Name:	Telephone:
Address:	Email:
Signed:	Date:

Address: 170 Queensway, Billingham, Teesside, TS23 2NT
T: 01642 554667 F: 01642 531799 E: dental@queensway.co.uk W: www.queensway.co.uk
For additional copies of this referral form please refer to our website