OUTPATIENT DENTAL GENERAL ANAESTHETIC SERVICE

REFERRAL FOR EXTRACTIONS: (FORM 1)

Name of Patient ……………………………………………………………………………………… Date of Birth…………………………………..

Address………

……

……

Post Code……………………………………………………………………………… Tel.No……………………………………………………………………

Full Name of Parent/Legal Guardian ……

Duties of Referring Dentist

1. I confirm that the treatment plan takes into account the presence/absence of permanent teeth.
2. I confirm that the relevant radiographs are enclosed in the case of permanent/sound deciduous teeth.
3. I confirm that relevant blood test results e.g. sickle cell, thalassaemia are *Enclosed/not required. **(*delete as necessary)**
4. I confirm that the patient is unable to accept dental extractions under local anaesthetic.
5. I confirm that appropriate alternative methods of pain/anxiety control, including the use of local anaesthesia, have been explained to the patient/parent/legal guardian.
6. I confirm that the risks associated with general anaesthesia for dentistry have been explained to the patient/parent/legal guardian.
7. **I enclose Forms 1 and 2: Referral for Extractions and Form 3: Confidential Medical History.**

Signature of Referring Dentist………………………………………………

Print Name……………………………………………………………………

Date ………………………………………

To be completed by patient/parent/legal guardian

1. I confirm that the risks associated with the provision of a general anaesthetic have been fully explained to me.
2. I confirm that all appropriate alternative methods of pain control have been explained to me.
3. I confirm that I request the dental procedure to be carried out under general anaesthesia.

Practice Address & Tel. No

(Rubber Stamp)

(Patient/Parent/Legal Guardian)

Signed………………………………………………………………………………Delete as necessary

Date………………………………………….