OUTPATIENT DENTAL GENERAL ANAESTHETIC SERVICE

REFERRAL FOR EXTRACTIONS: (FORM 2)

Name of Patient…….. Date of Birth ……

To be completed by referring dentist:

History of present complaint:

……

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Relevant past dental history: ……

……..

……

Justification for referral for treatment under general anaesthetic: ……

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……

Treatment

Teeth to be extracted: Please circle separately, signify roots to be extracted by X above the tooth and supplemental/supernumery teeth by S

Permanent Teeth

R	8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8	L
	8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8	

Deciduous Teeth

R	E D C B A	A B C D E	L
	E D C B A	A B C D E	

If permanent teeth or sound deciduous molars are to be extracted radiographs to check for the presence of unerupted teeth are required.

Please outline your treatment plan for any carious teeth which are **not** to be extracted: ……

……..

……..

Is an interpreter required? Yes/No Language……..

NB: The treating dentist retains responsibility for the treatment undertaken Under GA.

Practice Address & Tel. No

(Rubber Stamp)

Signature of Dental Surgeon: ……

Date……