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| PATIENT’S DETAILS |

TITLE: ....................................................... DATE OF BIRTH: .........................................................

FIRST NAME: ............................................ SURNAME: ..................................................................

ADDRESS: .................................................................................................................................................

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POSTCODE: ............................................. TELEPHONE: ..........................................................................

EMAIL: ............................................................................................

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| MEDICAL HISTORY: PLEASE PROVIDE A BRIEF OUTLINE(THE SEDATIONIST WILL CHECK PATIENT’S MEDICAL HISTORY IN FULL AT ASSESSMENT.)  |

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| REASON FOR REFERRAL |

TREATMENT REQUIRED: ..........................................................................................................................

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DO YOU HAVE RELEVANT RADIOGRAPHS: YES / NO Please email radiographs to wisdom.dentalcare@nhs.net.

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| REFERRER DETAILS  |

NAME: ..................................................... SURNAME: .................................................................

PRACTICE ADDRESS: ................................................................................................................................

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POSTCODE: ............................................. TELEPHONE: ..............................................................

EMAIL: ..............................................................................................

I HAVE EXPLAINED THE PROCEDURE TO THE PATIENT AND DISCUSSED ALTERNATIVE MEANS OF CARE WHERE APPROPRIATE. THE PATIENT NAMED ABOVE HAS GIVEN CONSENT FOR THIS REFERRAL TO BE MADE ON THEIR BEHALF, FOR POTENTIAL TREATMENT UNDER INTRAVENOUS SEDATION.