RESTORATIVE DENTISTRY REFERRAL

THE NIGHTINGALE CLINIC
nightingale.clinic1@nhs.net
679 Barking Road, London, E13 9EU | Call 020 8548 1288

PATIENT DETAILS

Patient's Title:	First Name:	Surname:	Gender:	Date of Birth:

	Postcode:

Patient's Contact Number (Mobile preferred):	Patient's Email Address:

MEDICAL HISTORY

- ☐ Allergies
- ☐ Heart problems
- ☐ High blood pressure
- ☐ COPD/ Chest problems
- ☐ Epilepsy/ Neurological conditions
- ☐ Diabetes/ Thyroid/ Endocrine conditions
- ☐ Bleeding disorders
- ☐ Sickle cell anaemia
- ☐ Gastric problems
- ☐ Liver problems/ Hepatitis
- ☐ Kidney problems
- ☐ HIV/ TB/ CJD
- ☐ Osteoporosis/ Joint/ Bone conditions
- ☐ Skin conditions
- ☐ Mental health conditions
- ☐ Smoking or tobacco use
- ☐ Alcohol use
- ☐ Undergoing chemotherapy
- ☐ Radiotherapy of head or neck
- ☐ Taking bisphosphonates (Oral or IV)
- ☐ Anti-coagulants/ anti-platelet medication
- ☐ Any operations
- ☐ Learning disability
- ☐ Visual impairment
- ☐ Hearing impairment
- ☐ Mobility impairment

Please give further details of medical conditions and medications

REFERRAL DETAILS

Patient's complaint or main concern:

Details and history of presenting condition:
Reason for referral:

Details of treatment already received for referred condition including dates:

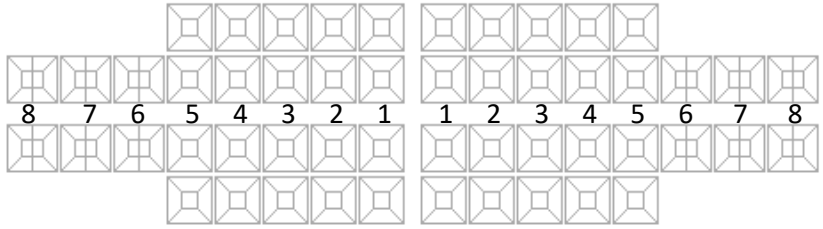
Most recent BPE score ☐☐☐
recorded on DD/MM/YY ☐☐☐

Justification for treatment under sedation: (Patient to complete)

	Yes	No
I could not have my treatment without sedation	☐	☐
Without sedation, I may cancel or not attend my next appointment	☐	☐
I asked for my dental treatment to be provided under sedation	☐	☐
My dentist suggested that I have treatment under sedation	☐	☐
I don't usually have sedation, but my treatment is complex today	☐	☐
I always ask for sedation for any form of dental treatment, and will do so in the future	☐	☐
I always had sedation for my treatment in the past	☐	☐
I have cancelled my appointments in the past because sedation was not offered	☐	☐

How anxious are you about the dental procedure you are being referred for on a scale of 1-5? (1 = not anxious, 5 = extremely anxious) ① ② ③ ④ ⑤

CHARTING OF TEETH, INCLUDING SURFACES, REQUIRING RESTORATIVE WORK



Notes:

REFERRER DETAILS

Referring Practice nhs.net email address:	Referring GDP:	GDC Number:

Referring Practice phone number:

- ☐ Clinically diagnostic relevant radiographs are attached
- ☐ I confirm that a full mouth examination was carried out
- ☐ I confirm that the patient consents to this referral and understands the reasons for it
- ☐ I confirm that alternative methods of pain and anxiety relief have been discussed
- ☐ I confirm that the patient is aware that a referral for IV sedation (Additional Services) means that they pay for a separate course of treatment at the Nightingale Clinic

Practice Stamp

Referrer Signature **Date**

Fax to 020 8552 0850 or post to 679 Barking Road, Plaistow, E13 9EU, or email to nightingale.clinic1@nhs.net
Please complete ALL sections. Failure to do so may lead to the form being returned for further information