GENERAL ANAESTHETIC REFERRAL TO CDS

Name of Patient: ________________________________ Patient DOB: ________ Male/Female (please circle)

Address of Patient:

Interpreter Required: Y/N

Primary Language: ____________________________

GMP: _______________________________________

Name of Parent/Guardian: ________________________

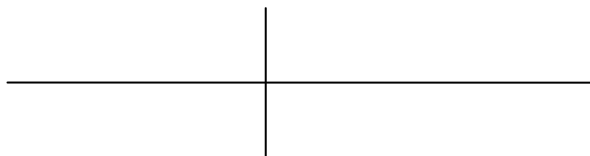
Address:

Daytime Telephone:______________________________

Mobile Telephone:_______________________________

Telephone number ____________________________

Proposed Dental Extractions



Radiographs: Please enclose any recent radiographs. These will be returned after treatment is completed

Reason for GA Referral (please tick all that apply)

Anxiety: ☐

Young age: ☐

Multiple Ext: ☐

Failed LA ext: ☐

Inability to cooperate: ☐

Other: (please print)_______________________________

Has this patient had GA before Y/N *If yes when*:

Medical History *(please attach medical history form)*

I confirm that I have discussed the risks involved with General Anaesthesia with the patient/parent/guardian and I am satisfied that all other options have been discussed or attempted.

Signature Referring Dentist: ____ **Date**:______________________

Print Name ____

Dentist Address:

Telephone Number: ________________________