Oral Surgery Referral

Hillcrest Dental Practice

Patient Details	Referrer Details
Surname:	Surname:
First name:	First name:
Date of Birth:	GDC no:
Address:	Practice Address:
Contact Numbers:	Contact no:
home: mob:	
Email Address:	Email Address:

Reason for Referral:

Conscious Sedation Required? Yes ☐ No ☐

Radiographs Attached? Yes ☐ No ☐

Date of Referral: _____

Signature: _____

Please send completed Referrals to:

reception.hillcrestdental@gmail.com

or

Hillcrest Dental Practice
Bickington Road
Barnstaple
EX31 2DB

Please complete attached Medical History

Confidential Medical History

Name: Date of Birth:

Address: Telephone:

Occupation:

Have you ever suffered from or had: [please give details]

Heart problems, heart surgery, high blood pressure?

Blood or bleeding disorders?

Do you take any blood thinning medication?

Have you ever taken any “bone strengthening medication” for osteoporosis, tablet or intravenous infusion?

Chest or breathing problems, asthma, bronchitis or shortness of breath?

Do you smoke cigarettes, cigars or smoke a pipe?

Jaundice, hepatitis or other liver disorders?

Stomach ulcers, or have you been instructed to avoid aspirin/ibuprofen?

Kidney problems?

Fits, epilepsy or other neurological problem?

Sickle Cell Disorder?

Sleep apnoea?

Diabetes?

If appropriate, could you be pregnant, are you breast feeding?

Do you have any allergies? e.g. Latex

Are you allergic to Penicillin?

Have you ever had any adverse reaction to local anaesthetic or sedatives?

Do you have any other medical condition of relevance?

Please list all medication that has been prescribed by your doctor/specialist and any “over the counter” medication:

Signed……

Date…….