**Devon, Cornwall and Isles of Scilly Area Team**

**Adult - Oral & Maxillofacial Surgery GA or Sedation Request Form**

 **(Form 2)**

**Patient details:**

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| --- | --- |
| Title:       |  Address:       |
| Forename(s):        |       |
| Surname:       |       |
| Sex:       |       |
| Date of birth:       |       |
| NHS Number:       |  Postcode:       |
| Telephone numbers: Home:        Mobile:       |

**Referring Practitioner:**

|  |
| --- |
| Name:       |
| Address:       |
| Telephone Number:        |
| Fax Number:       |
| Does the patient have a disability? YES [ ]  NO [ ] If yes, please specify:       |

**Procedure:**

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| Please give details of the procedure to be carried out:       |
| Referring to the guidelines on GA and Sedation, please give details of why this patient requires sedation or a General Anaesthetic:       |
| Is the patient able to have routine dentistry performed under local anaesthetic: Y [ ]  N [ ]  |

**Declaration:**

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| --- |
| **Dentist:**I have explained to the patient that Sedation and General Anaesthesia carries an increased level of risk and should not be used as a routine alternative.**Name:** **Signed : Date:** **Patient:**I understand that Sedation or General Anaesthesia carries an increased level of risk and should not be used as a routine alternative to local anaesthesia (the normal injection you have for fillings).**Name:** **Signed :** **Date:**  |