# Plymouth Community Dental Service

# General Anaesthesia Referral

# This service only provides extractions under GA for patients under 16yrs

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| Patient’s Name: | | Date of Birth: | |
| Address: | | | Telephone Number: Home:  Mobile |
| Postcode: | NHS Number: | | **Parental Responsibility:** |

**Please would you extract the following teeth, under General Anaesthesia**

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**(use upper case letters for deciduous teeth)**

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| **Please repeat the extractions required, in long hand** |

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| **I will include an OPTG X ray( vinyl, digital or paper copy) if permanent teeth are to be extracted; I understand that this** **will be sent back to me in due course** | Yes / No /Not available |

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| Medical History of Patient **Please ensure that the PCDS medical history form enclosed with this referral is completed, checked, dated and signed** |

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| Relevant Past Dental History of Patient |

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| **I have discussed the risks of General Anaesthesia with the patient and their parent/legal guardian, and made them aware of alternative forms of pain control. I consider General Anaesthesia to be necessary because:** | | |
| 1. The patient is too young to accept local analgesia |  |
| 1. The patient requires multiple extractions |  |
| 1. They have an acute infection with cellulitis |  |
| 1. Other, please explain below: |  |

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| **Name and Signature of Referring Dentist:** | **Practice Stamp:** |
| Date: |  |

**NB: All referral for General Anaesthesia must be on this form, in order to comply with our clinical governance requirements.**

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| **Name** | **Address**  **Postcode** | | | **Contact telephone numbers** |
| **Date of Birth** | **Ethnic group** |
| **Email address** | **GP Surgery** |
| **Parental responsibility (children only)** |
| **Do you have/have you had:** | | **NO** | **YES** | **Please give details** |
| **Heart** disease, surgery, murmur, rheumatic fever | |  |  |  |
| **Chest pain**, angina, swollen ankles | |  |  |
| High/low **blood pressure** | |  |  |
| **Pacemaker**, thrombosis/**blood clots**, other | |  |  |
| Bronchitis, pneumonia, pleurisy, **chest problems** | |  |  |
| Emphysema, chest surgery, cystic fibrosis, **COPD** | |  |  |
| Breathlessness with exercise or at night, **sleep apnoea**, other condition | |  |  |
| **Hepatitis B, C, HIV**, blood transfusion | |  |  |
| **Bleeding** problems, excessive bruising | |  |  |
| **Anaemia**, sickle cell | |  |  |
| Haemophilia, other **bleeding disorder** | |  |  |
| **Diabetes** | |  |  |
| Jaundice or **liver** disease | |  |  |
| **Kidney** or urinary problems | |  |  |
| **Epilepsy**, convulsions, fits | |  |  |
| **Faint** easily | |  |  |
| Indigestion, hiatus hernia | |  |  |
| **General anaesthetics** for operations including dental treatment - *If YES were there any problems?* | |  |  |
| **Asthma**, eczema or hayfever | |  |  |
| **Allergies**/reactions to medicines, drugs, **penicillin**, foods elastoplast, latex | |  |  |
| Any inherited disease in the family | |  |  |
| **Mental health problems**, learning disability or syndrome etc | |  |  |
| Any other illnesses or conditions e.g. **osteoporosis, cancer** | |  |  |
| Are you **pregnant**, or think you might be? | |  |  |
| Are you **breastfeeding?** | |  |  |
| **Taking any medicines, drugs, pills, inhalers, suppositories, skin creams, contraceptive pill etc.** | |  |  |
| Are you taking/had any **steroids** in the past year | |  |  |
| Have had tablets or injections to protect your bones or for arthritis | |  |  |
| What do you **weigh**? STONES / KGS | |  | |
| Do you drink **alcohol**? YES / NO ……………..Units per week/day | |  | |
| Do you **smoke**? YES / NO …………….Cigarettes/other per day | |  | |
| Do you use **smokeless tobacco** e.g. chewing, betel nut, areca | |  |  |
| Do you use **recreational** drugs? | |  |  |

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| Have you or your child ever been known by another name  If yes please give details |  |
| Preferred method of contact  i.e. Home phone, mobile phone, text, email |  |
| Consent to leave message on mobile phone or land line answerphone with information relating to appointments. |  |

Date..................... Signature..................................... Relationship to patient...................................

Checked date…………………. Dentist’s signature …………………………………. Dentist’s initials ………………….

**\*\* PLEASE BRING A LIST/PRESCRIPTION OF YOUR CURRENT MEDICATIONS WITH YOU\*\***