**THIS FORM MUST ACCOMPANY THE RELEVANT ORAL SURGERY REFERRAL FORM**

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| --- |
| **PATIENT DETAILS** |
| **Surname: …………………………………….……………… First name: ……………………..……………… Date of Birth: ………………….………** |
| **REFERRAL INFORMATION** |
| **Name of Provider to Receive referral ( )**  |
| **FULL PATIENT DETAILS** | **REFERRER DETAILS** |
| **Mr** [ ]  **Mrs** [ ]  **Miss** [ ]  **Ms** [ ]  **Dr ☐ Other** [ ] **Male** [ ]  **Female** [ ]  **NHS Number:****Surname:****First name:****Date of Birth:** | **Mr** [ ]  **Mrs** [ ]  **Miss** [ ]  **Ms** [ ]  **Dr** [ ]  **Other** [ ] **Surname:****First name:****Job Title:****GDC/GMC Number:** |
| **ADDITIONAL INFORMATION** |
| **Justification for Sedation request. (tick all that apply)****Anxiety** [ ] **Lack of Co-operation** [ ] **Needle Phobic** [ ] **Pronounced Gag Reflex** [ ] **Other Please state** [ ]  |
| **DETAILS OF PREVIOUS:****DENTAL TREATMENT / ONGOING DENTAL TREATMENT /PREVIOUS SEDATION/PREVIOUS GENERAL ANAESTHETICS**  |
| **Has the patient used any recreational drugs currently or in the past?****Cannabis / Skunk** [ ] **Benzodiazepines** [ ] **Intravenous drugs** [ ] **Give additional details:** |
| **ANXIETY SCALE: MODIFIED DENTAL ANXIETY SCALE FOR PATIENTS OVER 12 YEARS** *Please ask your patients aged 12 and over to complete the MDAS patient questionnaire – see appendix.* **Total Score = …………….** |
| **Patients BMI = …………***Score see appendix below.**Patients with a BMI over 40 will need to be informed that individual assessment may be required and sedation may not be available.*  |
| **Is the patient pregnant?** YES [ ]  NO [ ]  |
| **PATIENT CONSENT TO REFERRAL AND ASSOCIATED TREATMENT** |
| Has the patient understood and consented to the referral? YES [ ]  NO [ ] Patient Signature accepting the condition of referral to be considered for sedation …………………………………… |
| **CONFIRMATION AND SIGNATURE OF REFERRING PRACTITIONER** |
| **I confirm that this patient referral meets the current referral guidelines as issued by the Southwest LDN.** *(Referral guidelines are available on the LDN website).*I understand that incomplete and/or inappropriate referrals will be returned for revision and may delay patient treatment. Please note that it is now a mandatory requirement for referrers to provide their GDC or GMC Number on this form.**Please tick to confirm.** [ ]  |
| **Print Full Name:………………………………………………………………………………………………… Date:………………………….................****Signature: ………………………………………………………………………………** |
| **MODIFIED DENTAL ANXIETY SCORE QUESTIONNAIRE**. *Please score patient anxiety questionnaire as below.* Each of the five answers is scored as follows: **Not anxious** = 1 **Slightly anxious** = 2 **Fairly anxious** = 3 **Very anxious** = 4 **Extremely anxious** = 5 So, the total Questionnaire Score is a sum of all five items (range 5 to 25)**Please convert the questionnaire score to a rank score as below and record this on the referral form.** MDAS 5-9(minimal anxiety)MDAS 10-12(moderate anxiety)MDAS 13-17(high anxiety)MDAS 18-25(very high anxiety) |

**Details for where to refer in your region are found at page 21 onward in the Oral Surgery Referral Guidance Document access from the link** [**Here**](https://www.england.nhs.uk/south/info-professional/dental/dcis/forms/%20%20%20%20%20)

**For Somerset Primary Care DwSI MOS Referrals Indicate requested provider stating “DAC Bridgwater • Frome • Taunton • or Yeovil”**

**If in doubt, contact your local Oral Surgery Provider.**

**If you feel the case is urgent but not suspected cancer, please contact your local provider in person to discuss.**

**For all suspected cancer cases please use the Relevant 2 Week Wait referral form which can be accessed from the link**

[Here](https://www.england.nhs.uk/south/info-professional/dental/dcis/forms/)

# **CAN YOU TELL US HOW ANXIOUS YOU GET, IF AT ALL, WITH YOUR DENTAL VISIT?**

## PLEASE INDICATE BY INSERTING ‘X’ IN THE APPROPRIATE BOX

|  |
| --- |
| 1. **If you went to your Dentist for TREATMENT TOMORROW, how would you feel?**
 |
|  | *Not* *Anxious* [ ]  | *Slightly* *Anxious* [ ]  | *Fairly* *Anxious* [ ]  | *Very* *Anxious* [ ]  | *Extremely* *Anxious* [ ]  |
|  |
| 1. **If you were sitting in the WAITING ROOM (waiting for treatment), how would you feel?**
 |
|  | *Not* *Anxious* [ ]  | *Slightly* *Anxious* [ ]  | *Fairly* *Anxious* [ ]  | *Very* *Anxious* [ ]  | Extremely *Anxious* [ ]  |
|  |
| 1. **If you were about to have a TOOTH DRILLED, how would you feel?**
 |
|  | *Not* *Anxious* [ ]  | *Slightly* *Anxious* [ ]  | *Fairly* *Anxious* [ ]  | *Very* *Anxious* [ ]  | Extremely *Anxious* [ ]  |
|  |
| 1. **If you were about to have your TEETH SCALED AND POLISHED, how would you feel?**
 |
|  | *Not* *Anxious* [ ]  | *Slightly* *Anxious* [ ]  | *Fairly* *Anxious* [ ]  | *Very* *Anxious* [ ]  | Extremely *Anxious* [ ]  |
|  |
| **If you were about to have a LOCAL ANAESTHETIC INJECTION in your gum, above an upper back tooth, how would you feel?** |
|  | *Not* Anxious [ ]  | *Slightly* Anxious [ ]  | *Fairly* Anxious [ ]   | *Very* Anxious [ ]   | Extremely Anxious [ ]  |

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#### Instructions for scoring (remove this section below before copying for use with patients)

The Modified Dental Anxiety Scale. Each item scored as follows:

Not anxious = 1

Slightly anxious = 2

Fairly anxious = 3

Very anxious = 4

Extremely anxious = 5

Total score is a sum of all five items, range 5 to 25: Cut off is 19 or above which indicates a highly dentally anxious patient, possibly dentally phobic.



Link to NHS BMI Calculator [Here](https://www.nhs.uk/live-well/healthy-weight/bmi-calculator/)