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

|  |  |
| --- | --- |
| **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 | ExtremelyAnxious |

#### \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#### 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

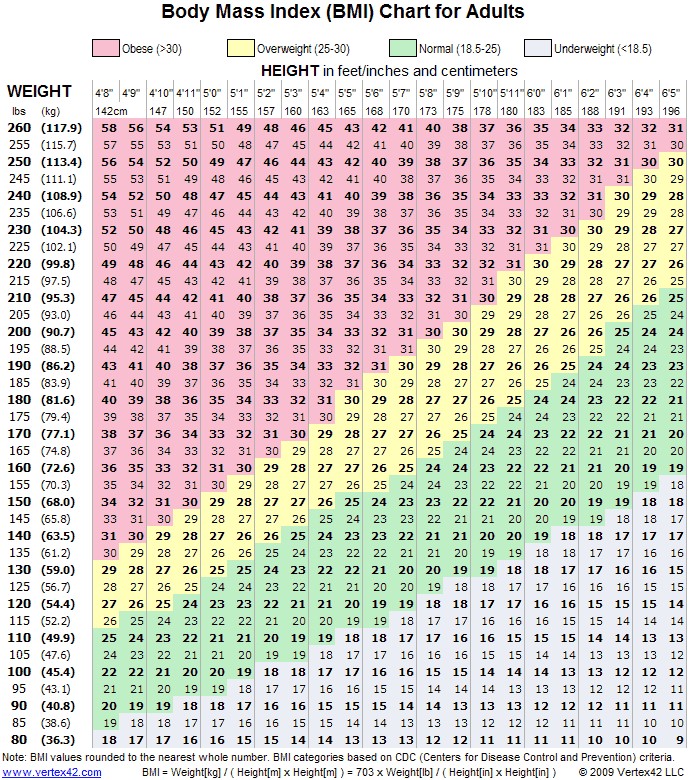
Slightly anxious = 2

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/)