slade dental practice
& implant centre

SEDATION REFERRAL

Patient Details

Surname: | First Name: | D.O.B:

Address: | Email:

Tel Home:

Tel Mobile:

Reason for Sedation Request

Treatment to be carried out under sedation

Relevant Medical History (including smoking history)

Referrer Details

Dentist: | GDC no:

Address: | Email:

Tel Practice:

Tel Other:

Fax:

Signature:

We will contact the patient to arrange a mutually convenient appointment.

Print & fax form to: 02088551351
Print & email to: info@sladeimplantcentre.com
Send form to: Implant Co-ordinator, Slade Implant Centre, 1-3 Garland Road, Plumstead Common, London SE18 2RU
Phone Us: **02088552115**