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| Primary Care Dental Service, Somerset – NHS England South West Referral FormRequest for Assessment of Patients with Additional Needs in Somerset |

**Please note that if your referral does not meet the Primary Care Dental Service criteria or if this form is not legible or completed fully, we reserve the right to return it to you.**

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| **SECTION 1 REFERRAL INFORMATION** | | | | | |
| Do you consider this to be an urgent referral? | Yes  No | If yes, please state why |  | | |
| **SECTION 2 PATIENT DETAIL** | | | **SECTION 3 PARENT/CARER/GUARDIAN INFORMATION** | | |
| First Name |  | | First Name |  | |
| Surname |  | | Surname |  | |
| Address |  | | Address |  | |
|  |  | |  |  | |
|  |  | |  |  | |
| Postcode |  | | Postcode |  | |
| Home Tel. No. |  | | Home Tel. No. |  | |
| Mobile Number |  | | Mobile Number |  | |
| Email address |  | | Email address |  | |
| Date of Birth |  | | Relationship to patient |  | |
| Name of School/Nursery (if patient under 16) |  | | Is there a social worker or learning disability team involved? Yes  If yes, please give details | | |
| Gender | Male  Female  Other | |
| NHS Number |  | |
| **SECTION 4 REFERRER DETAILS** | | | **SECTION 5 PATIENT GP DETAILS (if not the referrer)** | | |
| First Name |  | | First Name |  | |
| Surname |  | | Surname |  | |
| Registration number |  | | Practice Address |  | |
| Address |  | |  |  | |
|  |  | |  |  | |
|  |  | |  |  | |
| Postcode |  | | Practice Postcode |  | |
| Tel. No. |  | | Practice Tel. No. |  | |
| Email Address |  | | Email Address |  | |
| **SECTION 6 COMMUNICATION AND SPECIAL REQUIREMENTS** | | | | | |
| **First language if not English** |  | | Interpreter required | Yes | |
| **Sensory impairment** | Hearing | | Vision | Communication | |
| **Mobility** | Can manage stairs | | Can walk with frame | Can weight bear | |
| Wheelchair user | Can transfer by self | | Wheelchair tipper |  | |
| **Does the patient have any** **additional needs**? *please tick all that apply* | Learning disability | | | | Yes |
| Acquired brain injuries | | | | Yes |
| Diagnosed mental health illness | | | | Yes |
| Autistic spectrum disorders | | | | Yes |
| Current significant misuse of substances | | | | Yes |
| Child with cleft lip or palate | | | | Yes |
| Dental treatment complicated by medical condition | | | | Yes |
| Medical condition significantly affected by poor oral health | | | | Yes |
| Sensory disability making access to general dental service difficult | | | | Yes |
| Physical disability making access to general dental service difficult | | | | Yes |
| Access to bariatric chair needed (patient is over 21 stone / 133 kg) | | | | Yes |
| If yes, please specify the weight of the patient | | | |  |
| Children with a high level of anxiety or children with a phobia of dental treatment and/or children with behavioural difficulties (treatment must have been attempted in GDP first) | | | | Yes |
| **SECTION 7 REASON FOR REFERRAL AND TREATMENT REQUESTED** | | | | | |
| **Please explain why you are referring the patient and what treatment is required**  **Extractions:**    R  L  ***8 7 6 5 4 3 2 1 1 2 3 4 5 6 7 8***  ***8 7 6 5 4 3 2 1 1 2 3 4 5 6 7 8***      ***E D C B A A B C D E***  ***E D C B A A B C D E***      **Restorations:**    R  L  ***8 7 6 5 4 3 2 1 1 2 3 4 5 6 7 8***  ***8 7 6 5 4 3 2 1 1 2 3 4 5 6 7 8***      ***E D C B A A B C D E***  ***E D C B A A B C D E***      **Other:** | | | | | |
| **SECTION 8 DESCRIBE PREVIOUS ATTEMPTS AT TREATMENT** | | | | | |
| **Please explain what treatment attempted and why the patient cannot be treated within General Dental Practice** | | | | | |
| **SECTION 9 RADIOGRAPHS** | | | | | |
| **Radiographs are required for patient assessment**  **Please ensure all relevant and recent radiographs are enclosed** | | | | | |
| **Radiographs enclosed:** | DPT | | Intra Orals | None (give reason) | |
| **SECTION 10 CHECKLIST** | | | | | |
| The above referral has been discussed and agreed with the patient and/or Parent/Guardian | | | | | Yes |
| I understand that the final decision for treatment offered rests with the PCDS Dental Officer following discussions with the patient/parent/carer. When appropriate, consultation with the General Dental Practitioner will be undertaken | | | | | Yes |
| I understand that NHS charges are payable to PCDS unless the patient is exempt and that NHS charges have only been raised for treatment already carried out. | | | | | Yes |
| I have enclosed a Personal Treatment Plan form FP17RN. Charges will be payable for work carried out by PCDS. | | | | | Yes |
| Recent relevant X-ray enclosed | | | | | Yes |
| Signed Primary Care Dental Service medical history form/appropriate practice medical history form enclosed | | | | | Yes |
| I confirm that this patient referral meets the current referral guidelines. I understand that incomplete and/or inappropriate referrals will be returned for revision and may delay patient treatment. | | | | | Yes |
| **SECTION 11 SIGNATURE** | | | | | |
| **Print Name** |  | | **Signature** |  | |
| **Registration Number** |  | | **Date** |  | |

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| **SECTION 12 TRIAGE OUTCOME** | | | | |
| **Date Triaged** |  | **Triaged by (print name and position)** | | | |
| **Referral Accepted** | Yes  No | **If rejected, please state reason for rejection** | | | |
| **Patient Complexity** | Level 1 | | Level 2 | Level 3 | |

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| Primary Care Dental Service – NHS England South West Medical History FormMedical history form must accompany the PCDS referral form |

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| **SECTION 13 PATIENT’S DETAILS** | | | | | | | |
| **Patient’s Name** | |  | **Date of Birth** | | | |  |
| **SECTION 14 PATIENT MEDICATIONS** | | | | | | | |
| **Please list all current medications** | | | | | | | |
| **SECTION 15 CONFIDENTIAL MEDICAL HISTORY FORM** | | | | | | | |
| **PLEASE ANSWER *ALL* QUESTIONS** | | | | **YES** | **NO** | **DETAILS – PLEASE STATE** | |
| Has the patient ever been admitted to hospital? | | | |  |  |  | |
| Has the patient had any operations? | | | | ☐ | ☐ |  | |
| Is this patient attending or receiving treatment from a doctor, hospital, clinic or specialist? | | | | ☐ | ☐ |  | |
| Has the patient ever had a general anaesthetic?  If YES, where, when and what for? | | | | ☐ | ☐ |  | |
| Has the patient had a bad reaction to a general or local anaesthetic? | | | | ☐ | ☐ |  | |
| Is the patient taking any medicines (tablets, creams, ointments, injections, other – including Warfarin, aspirin, contraceptives and HRT) or alternative remedies? *Please specify*  Please bring repeat prescription/MARS sheet (if applicable) | | | | ☐ | ☐ |  | |
| Is the patient taking or has taken steroids in the last two years? | | | | ☐ | ☐ |  | |
| Is the patient using or has ever used recreational drugs? | | | | ☐ | ☐ |  | |
| Is patient allergic to any medicines or food substances? | | | | ☐ | ☐ |  | |
| Does the patient suffer from Parkinson’s disease, motor neurone disease, or other neurological condition? | | | | ☐ | ☐ |  | |
| Has the patient ever been told they have a heart murmur, heart disease, high blood pressure, angina, heart attack, stroke or heart surgery? | | | | ☐ | ☐ |  | |
| Does the patient have a pacemaker, VNS implant, stent, artificial valve, shunt, or other form of implant? | | | | ☐ | ☐ |  | |
| Has the patient ever had jaundice, liver, kidney disease or hepatitis? | | | | ☐ | ☐ |  | |
| Does the patient suffer from allergies e.g hay fever or eczema? | | | | ☐ | ☐ |  | |
| Does the patient suffer from bronchitis, asthma or other chest conditions/snoring/sleep apnoea? | | | | ☐ | ☐ |  | |
| Does the patient have fainting attacks, giddiness, blackouts or epilepsy? | | | | ☐ | ☐ |  | |
| Does the patient have diabetes? | | | | ☐ | ☐ |  | |
| Does the patient have anaemia? | | | | ☐ | ☐ |  | |
| Has the patient ever bled excessively? | | | | ☐ | ☐ |  | |
| Does the patient suffer from any infectious diseases (including HIV, Hepatitis B or C)? | | | | ☐ | ☐ |  | |
| Has the patient ever been notified for public health purposes that they are at risk of CJD or vCJD? | | | | ☐ | ☐ |  | |
| Does the patient carry a warning card or a medi alert? | | | | ☐ | ☐ |  | |
| Does the patient have a TEP (Treatment Escalation Plan) – sometimes known as DNAR (Do Not Attempt Resuscitation)? | | | | ☐ | ☐ |  | |
| Does the patient drink alcohol – if so, how many units per week? | | | | ☐ | ☐ |  | |
| Does the patient smoke or chew tobacco products –  if so, how many per week? | | | | ☐ | ☐ |  | |
| Does the patient wish to receive advice about stopping smoking? | | | | ☐ | ☐ |  | |
| Does the patient have any physical, visual or hearing problems? | | | | ☐ | ☐ |  | |
| Does the patient have any behavioural or learning disabilities? | | | | ☐ | ☐ |  | |
| Does the patient have an Autism Spectrum Condition, or ADHD? | | | | ☐ | ☐ |  | |
| Has the patient ever had any mental health problems, including anxiety and panic attacks? | | | | ☐ | ☐ |  | |
| Is the patient pregnant or breastfeeding? | | | | ☐ | ☐ |  | |
| Is there anything else the dentist should know? | | | | ☐ | ☐ |  | |
| **SECTION 15 PATIENT/PARENT/CARER SIGNATURE** | | | | | | | |
| **Print Name** |  | | **Signature** | | |  | |
| **Date** |  | | | | | | |