Norfolk & Waveney Special Care Dental Service Referral Form

By sending this referral you confirm that:

- **The patient or their parent/guardian consents to the referral and that all options have been discussed**
- **The patient or their parent/guardian understands that their first visit will be for an assessment**
- **You remain responsible for emergency care whilst the patient is on our waiting list**
- **You remain responsible for preventative care in line with Delivering Better Oral Health**

A. Patient details:	**B. Referring Dentist Details:**
Title:..... Patient First Name:..... Patient Surname:..... Gender:..... Date of Birth: ..... NHS Number..... Address (include postal town): .... Postcode:..... Telephone (please tick preferred contact): ☐ Home:..... ☐ Work :..... ☐ Mobile:.....	Name:..... Performer No: ..... Address (or practice stamp):..... .... Postcode:..... Telephone:..... Email:.....

C. If contact needs to be through a parent/carer please give details below:

Name:..... Address.....

.....

Telephone (tick preferred contact): ☐ Home.....

☐ Work..... ☐ Mobile .....

Relationship to patient..... .....

D. Doctor (GP) Details:

Name:..... Address.....

Tel:..... .....

E. Reason for referral to special care dental service:

Note: Patients who, in the opinion of the assessing clinician, can be managed in general dental practice will be not be accepted by the service and will be discharged from the SCDS if they are assessed as no longer requiring specialist dental care. The SCDS may offer to provide shared care with the referring GDP where there are elements of their care that are suitable for GDS provision and elements that require specialist support.

What dental treatment does the patient currently need?

What treatment have you already provided and/or have you attempted to provide (with dates)?
What difficulties were encountered making further care in primary care impossible/inadvisable?
Is the patient's ability to communicate or capacity to consent impaired? (If yes, please give details)
F. Number and type of radiographs enclosed:
If no radiographs enclosed, please state reason. Referrals for extraction of permanent teeth MUST include up to date radiographs & referrals for orthodontic extractions MUST include OPG.
Radiographs Enclosed: No: ☐ Bitewings (s) No: ☐ Other Intraoral eg Periapical No: ☐ Panoramic Radiograph
G. Medical History (include list of all medication being taken)
H. Social History
I. Other Paperwork
Please enclose any paperwork/letters etc. that are relevant to your referral and list enclosures here. Referrals for orthodontic extractions MUST include a copy of the orthodontist's treatment plan or letter.

J. Category of Special Care Dental Need: Please tick the box which most accurately fits the patient's needs	
Anxiety or behaviour management (Please complete section K if patient referred for this reason)	
Medical Complexity	
Learning Disability	
Mobility limitations presenting a barrier to attending a general dental practice without additional support	
Other physical disability	
Mental Health Issues presenting a barrier to attending a general dental practice without additional support	
Bariatric/Plus-size services required where weight of patient exceeds safe limit of dental chair in practice. Please state weight.....	
Looked after children	
Other special care dentistry needs	
Please specify here details of the patient's special care need as ticked above, and any secondary special care needs	

K. Referrals for Anxiety or Behaviour Management: Please indicate why you have referred for this service	
Note: Patients referred for anxiety management services are normally discharged to the GDP after a single course of treatment. Patients who, in the opinion of the assessing clinician, can be managed in general dental practice without additional support or services will not be accepted for care with the SCDS.	
Patient requesting care with inhalation sedation **(Must be at least 6 years of age & able to co-operate)**	
Patient requesting care with IV sedation **(Must be at least 16 years of age)**	
Patient requesting care with GA **(Must be under 18 years and/or have additional needs)**	
Patient requiring behavioural management **We would expect that simple behavioural management such as desensitisation & longer appointments are provided by GDS services**	

L. ADDITIONAL NEEDS INFORMATION		**X**	**DETAILS**
Wheelchair user?	Yes		
	No		
Able to transfer to dental chair?	Yes		
	No		
Patient is housebound and requires domiciliary care?	Yes		
	No		

M. WHAT IS THE PATIENTS ETHNIC GROUP? Please put an X in the appropriate box.

White British		White Irish		Other white background		White & Black Caribbean	
White & Black African		White and Asian		Other mixed background		Asian or Asian British Indian	
Asian or Asian British Pakistan		Asian or Asian British Bangladeshi		Other Asian background		Black or Black British Caribbean	
Black or Black British African		Other Black background		Chinese		Patient declined	

REFERRER DECLARATION (PLEASE TICK BOXES BELOW)

☐ The patient and/or parent/legal guardian has agreed to this referral and understands why they have been referred.

☐ The patent/carer understands that their first visit will be an assessment only.

Please check all sections are completed fully. Incomplete forms will be returned.

Signature of referrer..... Date.....
DENTIST

Please print name..... Practice.....

Please send all completed referral forms to:

Norfolk and Waveney Community Dental Service Referral Centre
Epic Centre
Norwich Community Hospital
Norwich
NR2 3TU

Tel: 0333 2079954 for enquiries

Or email referral to: cdsnorfolk.referrals@nhs.net