Lancashire and South Cumbria

Specialist Paediatric Dentistry Referral Form (June 2019)

1. Patient Details:		
Gender: ☐ Male ☐ Female	NHS Number (if known):	DOB:
Title:	Patient's First Name:	Patient's Last Name:
Address:	Town or City:	Postcode:
Preferred contact: Letter ☐ Home tel no. ☐ Mobile ☐	Best Contact Number:	
Interpreter required: ☐ Yes ☐ No	Child Lives With: ☐ Parents ☐ Other	
Language: ……..	Is this a looked after child? ☐ Yes ☐ No	

2. Patient's General Medical Practitioner Details:	
GMP's name:	GMP practice address & postcode:
☐ Patient is not registered with a doctor	

3. Referrer Details (this form must be completed by named referrer):		
Referrer's name:	Job title & relationship to patient:	
GDC number:	Practice phone number:	Email address (nhs.net):
Practice name:		
Practice address:		Practice postcode:

4. Why is this patient being referred to specialist services (tick all that apply):

☐ Learning disability	☐ Multiple extractions	☐ Hypodontia
☐ Physical disability	☐ Co-operation issues	☐ Disorders of eruption
☐ Medically complex	☐ Dental anxiety	☐ Others, please specify:
☐ Mental health issues	☐ Enamel / dentine defects	……
☐ Trauma	☐ Dental anomalies	……

Please note, if you have selected dental anxiety from the options above, you must complete the following questions below

The patient has expressed / displayed severe anxiety / phobia about dental treatment?	☐ Yes ☐ No
The patient's anxiety is preventing them from accepting dental care?	☐ Yes ☐ No

The referring dentist has attempted to help the patient manage their anxiety by acclimatisation on at least 2 occasions:	☐ Yes ☐ No
The referring dentist can provide evidence of what preventative measures they have provided for the patient:	☐ Yes ☐ No
The patient is ready to have their dental phobia / anxiety addressed:	☐ Yes ☐ No
The patient understands they may be managed using a variety of techniques, which may include psychological therapies e.g. cognitive behavioural therapy (CBT):	☐ Yes ☐ No
The patient is aware there may be a need for multiple appointments to manage their treatment needs:	☐ Yes ☐ No

5. Treatment Needs:
What do you want specialist dental services to do? (tick all that apply and give full details): ☐ Advice ☐ Provision of part of a course of treatment that will completed by the GDP ☐ Single course of treatment ☐ Current and all future on-going oral health needs
Diagnosis and clinical history:
What are the patient's symptoms?
What treatment have you provided for this condition?
What treatment are you requesting?
Why can't this treatment be provided by the referrer?
Have you discussed this referral and any possible treatment options with the patient / parent / carer?

6. Medical History:
Please tell us about the patient's medical history:
Medication:
Allergies:
Any issues relating to: mobility / communication / cooperation / oral risk factors / legal barriers to care? Please specify:

7. Where would the patient prefer to be seen on their initial visit?

Please select your patients choice of clinic for the assessment appointment	☐ Ashton Health Centre, Preston PR2 1HR ☐ Barbara Castle Way HC, Blackburn BB2 1AX ☐ St Peters Centre, Burnley BB11 2DL ☐ Whitegate Drive Health Centre, Blackpool FY3 9ES ☐ St Anne's Health Centre, St Anne's FY8 2EP ☐ Moor Park Health and Leisure Centre, Bispham FY2 0JG ☐ Dental Access Centre, Morecambe LA4 5NN ☐ Royal Preston Hospital, Preston PR2 9HT ☐ Chorley & South Ribble District General Hospital, Chorley PR7 1PP

8. Radiographs (to be completed if referrer is a Dentist):

Relevant radiographic images have been :
☐ Emailed with referral form ☐ In Post ☐ Not included

☐ OPG (if requesting treatment on permanent molars) ☐ Periapical ☐ Bitewings

If you have not supplied radiographs, please state why:

If you are referring for orthodontic extractions you must send a copy of the orthodontist's treatment plan.
☐ Tick here if attached

For office use : URN……..