NHS England
South West Region

Special Care Dentistry Referral Form to Community Dental Services Adults and Children

For referral by Dental Professionals only

Please note:

- **If your referral does not meet the Special Care Dental Service criteria or if this form is not legible or completed fully, we reserve the right to return it to you.**
- **If the patient is accepted for a course of treatment this does not mean they will receive ongoing care on completion of the treatment.**
- **For Dorset referrals, please use the Vantage Rego DERS system**

SECTION 1: REFERRAL INFORMATION		
Type of Referral	Specialist Opinion only ☐ Shared Care ☐	Specialist Opinion and Treatment ☐

SECTION 2: PATIENT DETAILS		**SECTION 3: PARENT/CARER/GUARDIAN INFORMATION**	
Name		**Name**	
Address		**Address**	
Home Tel. No.		**Home Tel. No.**	
Mobile Number		**Mobile Number**	
Email address		**Email address**	
Date of Birth		**Relationship to patient**	
Nursery/School/College (if relevant)		Professionals involved in care (e.g. social worker, learning disability team)? If yes, please give details **Yes** ☐ **Details:**	
Gender			
Patient's NHS Number			
Relevant Safeguarding information			

SECTION 4: REFERRER DETAILS		**SECTION 5: PATIENT GP DETAILS**	
Name		**Name**	
Practice Address		**Practice Address**	
Tel. No.		**Practice Tel. No.**	
NHS.net email address		**NHS.net email address**	

SECTION 6: REASON FOR REFERRAL AND TREATMENT REQUESTED					
Learning Disability	☐	Autism Spectrum Disorder	☐	Mental Health Condition	☐
Medical Disability	☐	Dementia	☐	Physical Disability	☐

Please explain why you are referring the patient and what treatment is required

SECTION 7: DESCRIBE PREVIOUS ATTEMPTS AT TREATMENT Please explain what treatment has been attempted and why the patient cannot be treated within General Dental Practice

SECTION 8: MEDICAL HISTORY Please include an overview of the patient's medical history, a copy of their medication list, any known allergies, a copy of the latest clinical letter or any other information that may be pertinent to their dental care

SECTION 9: COMMUNICATION AND IDENTIFIED REASONABLE ADJUSTMENTS Please detail communication, mobility or other reasonable adjustments required by the patient below

SECTION 10: RADIOGRAPHS Please ensure all relevant and recent radiographs are enclosed for patient assessment	
Radiographs enclosed DPT ☐ Intra Orals ☐ Date taken:	None ☐ Please give reason for not providing radiographs)

SECTION 11: SIGNATURE			
Print Name		**Signature**	
GDC Number		**Date**	

SECTION 12: TRIAGE OUTCOME			
Date Triaged		**Triaged by (print name and position)**	
Referral Accepted		**If rejected, please state reason for rejection**	
Patient Complexity	☐ Level 1	☐ Level 2	☐ Level 3

Completed forms to be returned to the relevant provider:

Area	Details
Cornwall	ciosicb.rmsdentalreferrals@nhs.net
Plymouth	livewell.referralsplymouthcommunitydentistry@nhs.net
Torbay	sdc-dental.t-sd@nhs.net
Devon (excluding Plymouth and Torbay)	rduh.sds-referral@nhs.net
Somerset	SCWCSU.dentalwest@nhs.net
BNSSG & BaNES	primarycaredentalreferrals@uhbw.nhs.uk
Wiltshire and Swindon	gwh.dentaladmin.teamoffice@nhs.net
Gloucestershire	https://www.ghc.nhs.uk/our-teams-and-services/gloucestershire-specialist-dental-service/
Dorset	Vantage Rego (ref.management)