

**South West Region**

**Special Care Dentistry Referral Form for Community Dental Services**

**Adults and Children**

**For referrals made by Health and Social Care Professionals (non-dental) only**

Please read guidance notes before completing this form.

**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.**
* **Dentists should not use this form and should make referrals on the form for referral by Dental professionals**

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| **SECTION 1: PATIENT DETAILS** | | **SECTION 2: PARENT/CARER/GUARDIAN INFORMATION (to support appointments as appropriate)** | |
| **Name** |  | **Name** |  |
| **Address** | | **Address** | |
| **Home Tel. No.** |  | **Home Tel. No.** |  |
| **Mobile Number** |  | **Mobile Number** |  |
| **Email address** |  | **Email address** |  |
| **Date of Birth** |  | **Relationship to patient** |  |
| **Gender** |  | **Patient’s NHS Number** |  |
| **Nursery/School**  **College (if relevant)** |  | Professionals involved in care (e.g. social worker, learning disability team)? If yes, please give details **Yes**  **Details:** | |
| **Relevant Safeguarding Information** |  |

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| **SECTION 3: REFERRER DETAILS** | | **SECTION 4: PATIENT GP DETAILS** | |
| **Name** |  | **Name** |  |
| **Job Title** |  | **Practice Address** | |
| **Address** | |
| **Tel. No.** |  | **Practice Tel. No.** |  |
| **Email Address** |  | **Email Address** |  |

Please tick to confirm you have told the patient (and/or relatives/carer as appropriate) you are making this referral

Please tick to confirm this referral complies with the General Data Protection Regulation, so that information can be   
shared with other Health and Social Care Professionals if this is necessary and in the Patient’s Best Interest

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| **SECTION 5: MAIN REASON FOR REFERRAL** |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Learning Disability |  | Autism Spectrum Disorder |  | Mental Health Condition |  |
| Medical Disability |  | Dementia |  | Physical Disability |  |
| **Detail any other reasons for referral below:** | | | | | |

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| **SECTION 6: DENTAL PROBLEMS ABOUT THE PATIENT** |

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| Why does this referral need to be made to a specialist dental service rather than the patient seeing a general high street dentist? |  |
| How long ago did the patient last see a dentist? |  |
| Are they taking any medication for a dental problem? (please list) |  |
| **What concerns do you have about the patient’s mouth?** Please tick all which apply | |

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| --- | --- | --- | --- | --- | --- |
| The patient is in pain |  | Sore mouth |  | Swelling |  |
| Problem teeth |  | Problem gums |  | Ulcers |  |
| Lost false teeth |  | Broken false teeth |  | False teeth not fitting |  |
| Other – please detail below: | | | | | |
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| **SECTION 7: 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 8: COMMUNICATION AND IDENTIFIED REASONABLE ADJUSTMENTS**  Please detail communication, mobility or other reasonable adjustments required by the patient below | | | |
|  | | | |
| **SECTION 9: SIGNATURE** | | | |
| **Print Name** |  | **Signature** |  |
| **Job Title** |  | **Date** |  |

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| **SECTION 10: 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 |

**Please send this completed form to:**

|  |  |
| --- | --- |
| **Area** | **Details** |
| Cornwall | ciosicb.rmsdentalreferrals@nhs.net |
| Plymouth | [livewell.referralsplymouthcommunitydentistry@nhs.net](mailto:livewell.referralsplymouthcommunitydentistry@nhs.net) |
| Torbay | [sdc-dental.t-sd@nhs.net](mailto:sdc-dental.t-sd@nhs.net) |
| Devon (excluding Plymouth and Torbay) | rduh.sds-referral@nhs.net |
| Somerset | [spn-tr.somersetdentalspa@nhs.net](mailto:spn-tr.somersetdentalspa@nhs.net) |
| BNSSG & BaNES | [primarycaredentalreferrals@uhbw.nhs.uk](mailto:primarycaredentalreferrals@uhbw.nhs.uk) |
| Wiltshire and Swindon | [gwh.dentaladmin.teamoffice@nhs.net](mailto:gwh.dentaladmin.teamoffice@nhs.net) |
| Gloucestershire | <https://www.ghc.nhs.uk/our-teams-and-services/gloucestershire-specialist-dental-service/> |
| Dorset | [Spn-tr.DorsetDentalSPA@nhs.net](mailto:Spn-tr.DorsetDentalSPA@nhs.net) |

**Pre- Domiciliary – Questionnaire**

*Please complete all sections fully:*

**Environment (external & internal) Information**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Factor** | **Delete / Detail as appropriate** | | | | | | | | | | |
| Type of accommodation | House | Ground floor | | | 1st Floor or Higher (with lift) | 1st Floor or Higher (without lift) | | | Keypad/ key safe details | |  |
|  |  |  | | |  |  | | |  | |  |
|  | Own home | Residential care | | | Nursing home | Other | | | | | |
|  |  |  | | |  |  | | | | | |
| Parking | On-street | Car park/ off-road | | | Difficult |  | | | | | |
|  |  |  | | |  |  | | | | | |
| Instruction on how to find property (if appropriate) |  | | | | | | | | | | |
| Lighting | Well-lit | |  | Poorly lit | | |  | Not lit | |  | |
| Location in Home | Flat access | |  | 1-2 steps | | |  | Upstairs | |  | |
| Medical equipment available | Oxygen | | Yes  No | Monitoring | | | Yes  No | Defibrillator | | Yes  No | |

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| **Risk Factor** | **Delete / Detail as appropriate** | |
| Obstructions? | *For example, clutter, furniture, soiled flooring/furniture* | |
|  | |
| Will someone be present to support the patient at the time of the appointment? | Yes  No  Details: | |
| Animals present? | If yes, where? If they are not in a restricted space (for example, cage or tank), can they be put into a different room than those we need access to while the visit takes place? | |
|  | |
| Fire hazards (please delete or state as appropriate) | Smoking | Yes  No |
| Oxygen cylinders | Yes  No |
| Gas fire | Yes  No |
| Other |  |
| Access to patient | Small clean workspace available Yes  No  Privacy for visit obtainable Yes  No  Patient in a chair or confined to their bed? Yes  No  Details: | |
| Anything else to be aware of? |  | |

**Patient Consent and Communication Information**

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| --- | --- |
| **Risk Factor** | **Delete / Detail as appropriate** |
| Communication difficulties | Yes  No |
| Capacity to consent?  If No  Is there a Lasting Power of Attorney for health & welfare? Details please | Yes  No |
| Recommended summary plan for emergency care and treatment / do not attempt cardiopulmonary resuscitation or deprivation of liberty safeguards in place? | Yes  No  Please provide copy |
| Next of kin  Relationship  Contact No |  |
| Principle Carer  Name  Contact No |  |

**Patient Behaviour and Compliance Information**

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| --- | --- |
| **Risk Factor** | **Delete / Detail as appropriate** |
| Best time of day |  |
| Challenging behaviour | Yes  No  Details: |
| Previous incidents | Yes  No  Details: |
| Triggering Factors | Yes  No  Details: |

**Mobility assessment**

|  |  |
| --- | --- |
| **Factor** | **Delete / Detail as appropriate** |
| Does the patient access a local Dentist | Yes  No  Don’t know |
| Does the patient attend their doctor’s surgery | Yes  No  Don’t know |
| If the patient has to attend Hospital, how do they get there? | Car  Taxi  Hospital Transport  Stretcher |
| Does the patient attend any outside activities (hairdressers/ chiropodist/ club)  If so, how do they get there? | Yes  No  Don’t know |
| Patient’s mobility | Walks unaided / Walks with support / Wheelchair/ Bed Bound |

**Payment Details**

|  |  |
| --- | --- |
| **Risk Factor** | **Delete / Detail as appropriate** |
| Does the patient pay for dental treatment?  If any exemption, then which one of the below  HC2, Income Support, ESA, Pension Credit Guaranteed credit, Universal credit, Other  NHS eligibility checker  [www.nhsbsa.nhs.uk/check](http://www.nhsbsa.nhs.uk/check) | Yes  No  – if no, please state exemption |
| If the patient pays, who should be contacted for the patient? (Please give contact details if not the Patient ) |  |