Community Dental Service – Referral Form

Service Required: **Special Care Dentistry / Domiciliary / Sedation / Bariatric**

Patient Full Name:	
Address, including postcode:	
Tel No:	DOB:
Name of next of kin / carer: (if requires support to attend)	
Contact number:	
General Medical Practitioner Name, address and tel number	
Reason for referral:	

Dental complaint (Tick all applicable):	Pain		**Dental status** (Tick applicable):	Edentulous (no natural teeth)	
	Urgent			Dentate (has some natural teeth)	
	Non urgent				

Treatment requested (Tick all applicable):	New dentures / Denture Problems	
	Comprehensive dental treatment	
	Dental assessment	
Radiographs enclosed (Please circle): Yes / No	Sedation/GA assessment*	
	*Modified Dental Anxiety Score, if applicable:	

Medical conditions	
Medications	
Patient's weight & height	_____kg _____cm
Relevant social history	
How do they get to hospital appointments, if needed? (Circle)	Ambulance Car Other:

How is the patient's mobility?		Ability to communicate		Have they capacity to consent?	
Walks unaided		Full		Yes	
Needs assistance		Limited		No	
Needs hoist transfer		Other:		Don't Know	

Criteria for referral, please tick box(es) applicable for patients with:

Learning disability		**01**	Patients whose cognitive abilities are such that they are unable to manage their own oral care, particularly those who need carers to support their daily activities, including dental visits
Mental health problems		**02**	Patients with diagnosed mental illness who need additional skills and facilities to manage their oral care
Physical disabilities and access issues		**03**	Patients whose mobility / physical disability requires specialist facilities and / or skills to manage their oral care. i.e. hoists, recliners to facilitate transfer or access to patients' mouths
Complex medical needs		**04**	Complex medical conditions which affect their oral health and / or dental treatment, and require liaison with medical consultants
Anxiety and phobia		**05**	Patients for whom there is evidence that they have dental phobia and / or anxiety which affects their ability to receive dental treatment in GDS i.e. require sedation
Cognitive impairments		**06**	Patients with cognitive impairments i.e. Brain Injury, Dementia
Bariatric patients		**07**	Patients who exceed the weight limit of dental chairs
Vulnerable groups		**08**	Homeless people / substance misusers who are unable to access GDS
Frail older people		**09**	Older people who because of their frailty and complex medical / social needs are unable to access care in the GDS

Referrer:	**Address:**	**Designation:**	**Date:**
			Tel No:

Please return this form:
By post to: Community Dental Service, Dental Department Riverside Health Centre, Wellington St, Canton, Cardiff, CF11 9SH
BY FAX: 02920 190175

Outcome of Assessment - (for the Local Health Board's Triage System to complete)

Date referral processed		**Triaged by**	
		Justification / location	
Emergency care required			
For treatment by Special Care Team			
Patient requires CDS domiciliary care			
Patient requires sedation assessment			
Bariatric UDH / GDP			
Does not meet CDS criteria for dental care			
Requires care in hospital		ASA	