

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	<input type="checkbox"/>	Dental status (Tick applicable):	Edentulous (no natural teeth)	<input type="checkbox"/>
	Urgent	<input type="checkbox"/>		Dentate (has some natural teeth)	<input type="checkbox"/>
	Non urgent	<input type="checkbox"/>			

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

Medical conditions	
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Medications	
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Patient's weight & height	_____ kg	_____ cm
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Relevant social history	
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How do they get to hospital appointments, if needed? (Circle)	Ambulance	Car	Other:
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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	<input type="checkbox"/>	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	<input type="checkbox"/>	02 Patients with diagnosed mental illness who need additional skills and facilities to manage their oral care
Physical disabilities and access issues	<input type="checkbox"/>	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	<input type="checkbox"/>	04 Complex medical conditions which affect their oral health and / or dental treatment, and require liaison with medical consultants
Anxiety and phobia	<input type="checkbox"/>	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	<input type="checkbox"/>	06 Patients with cognitive impairments i.e. Brain Injury, Dementia
Bariatric patients	<input type="checkbox"/>	07 Patients who exceed the weight limit of dental chairs
Vulnerable groups	<input type="checkbox"/>	08 Homeless people / substance misusers who are unable to access GDS
Frail older people	<input type="checkbox"/>	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 Department, Kier Hardie Health Park, Aberdare Rd, Merthyr Tydfil, CF48 1BZ
BY FAX: 01685 351429

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

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