## SPECIAL CARE DENTAL REFERRAL FORM

ADULT Domiciliary Visit For Data Protection reasons this form should not be emailed

Mr Mrs	Ms Miss (dele	te as required)	ons this form shou	ia <b>not</b> be emailed	ρ		d and will be indicated delay paties		
First Name	1110 111100 (0010					Surgery ca	re ensures the b	est and	
Surname					• 5	SCDS surg	jeries are equipp	ed with	lifts
Date of Birth		NHS Number					o aid access options may be	limited di	ıring
Landline		Mobile			C	lomiciliary	care		
				Postcode			care is only appruly house bound		
Home Address					• E	Environme	ntal risk assessr	ment may	/
Current				Postcode	þ	revent do	miciliary care be	ing ollere	ea
Address (if different from above)	1 00.000				Referral Date				
Dentist Name						ent / famil	y carer aware	Yes /	/ No
Dentist						Patient aware SCDS not			
Address	Tel:				responsible for emergency Yes care before first appointment			Yes	/ No
Doctor Name					Doe	s patient h	nave capacity		
Doctor						onsent to t		Yes	/ No
Address		Tel:	Tel:			If NO please complete box below			
Current Med	ication & Relevant Medic	al History: Th	ne enclosed medical	history form	Ве	est Interes	st/Next of Kin C	ontact [	 Details
Current Medication & Relevant Medical History: The enclosed medical history form must be completed and attached to referral form. This will ensure prompt processing of the referral.				Nan	ne				
					Add	lress			
Reason for re	eferral & brief history of der	ital problem:			Tel.	No.			
					Ema	ail			
					Relationship				
					to p	atient			
Refe	rrer Name (please print)			Mobility Ass	essmer	nt Tick as a	appropriate		
			No mobility problems Sitting balance						
Signature of Referrer		Ho	Hoist transfer Someone could escort them to Dental Surg					ntal Surge	ery 🗌
Position of Referrer			Attends Doctor Surgery or other appointment outside their home			Able to weight bear			
		lst	truly house/bed bo	und	Wheelchair user				
		Tra	ansfer with aids			ld attend De taxi / ambu	ental Surgery if tra llance	nsported b	ру 📙
	Contact Address		Category of Exemption Tick as appropriate						
		F	Pays Dental Charges If no category is ticked the patient will automatically be charged the standard NHS Dental Charges						tically
			Possible category of ex				ption		
	Tel:	Inc	Income support			Name on a valid HC2 Certificate			
Discour			come based job see	ekers allowance		Name on	a valid NHS Tax C	redit	
Referral Der	rint this form and post to partment, Special Care Der 19 Rowden Hill, Community	ntal Su	ome related emplo pport Allowance	pyment &		Reduced	cost apply if name	d on HC3	
	ış Rowden Hill, Community I, Chippenham SN15 2AJ	Pe	Pension credit Guarantee Credit			Universal Credit			

Incomplete referrals will not be



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Male Fema	ale (delete as required)	Protection reasor	ns this form should	d <b>not</b> be emailed	processed	te referrals v and will be	returned to	
First Name					referrer and	delay patiei	n treatmen	
Surname						patient meeting re Dental Serv		
Date of Birth		NHS Number			patient will	be offered an	assessment	
Landline		Mobile				will not normal appointment	ly be offered	
Home Address				Postcode	the practice	st appointment e remains resp care of the pa	onsible for	
Current Address (if different from above)				Postcode	Referral Date			
Dentist Name					Patient / family of referral	carer aware	Yes / N	
Dentist Address		Tel:			Patient aware SCDS not responsible for emergency care before first appointment			
Doctor Name								
Doctor Address		Tel:			Does this person		Yes / N	
Name of Prim	ary Carer				Patient Ethnicity			
Relationship t	o patient							
Professionals	involved in Child's Care (e	.g. Social Work	ker). Name and o	contact details	required.			
Language or I	Method of Communication							
School / Nurs	ery attended by Child							
Contact detail	ls for school nurse							
Names of other	er children within the family	nhome (full nam	nes and DoB)					
Refe	errer Name (please print)			Mobility As	sessment Tick as ap	ppropriate		
		No	mobility problems	; []	Sitting balar	nce		
Signature of Referrer			ist transfer		Able to weight bear			
		Tra	nsfer with aids		Wheelchair	user		
	Position of Referrer	Cu	rrent Medication ntinue on separate	on & Relevant sheet if required	Medical History: (a.	ttach print out if a	available or	
	Contact Address							
T.		Re	ason for referral	& brief history	of dental problem:			
Tel:	print this form and post to:							
49	tment, Special Care Dental Se Rowden Hill, Community tal, Chippenham SN15 2AJ	ervice,						



SPECIAL CARE DENTAL REFERRAL FORM

ADULT able	to attend clinic For Da	ta Protection re	easons this form sho	uld <b>not</b> be emailed		d and will be		
Mr Mrs	Ms Miss (dele	te as required	)			nd delay patie		
First Name					Subject to     Special Co	o patient meeting Care Dental Serv	g criteria for	
Surname						ill be offered an		
Date of Birth		NHS Numb	er			nt will not normal st appointment	ly be offered	
Landline		Mobile				first appointment	t with SCDS,	
Home Address				Postcode		al Practice remai gency care of the		
Current Address (if different from above)				Postcode	Referral Date			
Dentist Name					Patient / famil of referral	y carer aware	Yes / No	
Dentist					Patient aware SCDS not			
Address		responsible for emergency Yes / N care before first appointment						
Doctor Name		<u> </u>			Doos nationt l	novo consoity		
Doctor					Does patient to to consent to		Yes / No	
Address			:		If NO please complete box be			
	lication & Relevant Medic	al History:	(attach print out if av	vailable or	Best Interes	t/Next of Kin C	ontact Details	
continue on separate sheet if required)				Name				
					Address			
Reason for re	eferral & brief history of der	ıtal problem:			Tel. No.			
					Email			
					Relationship to patient			
Refe	errer Name (please print)			Mobility Ass	essment Tick as	appropriate		
			No mobility problems		Sitting ba			
Signature of Referrer			Hoist transfer					
			Fransfer with aids		Wheelcha			
F	Position of Referrer							
				Category of Ex	cemption Tick as	appropriate		
Contact Address			Fals		incur a financial p			
		F	Pays Dental Charge	S	Names on a valid HC2 Certificate			
			Income Support Income based Job Seekers Allowance					
	Tel:		Income related Employment & Support Allowance		Reduced cost apply if named on HC3  Certificate that is valid during course			
Please print this form and post to: Referral Department, Special Care Dental Service, 49 Rowden Hill, Community			Support Allowance		of treatme		, 304.30	
			Pension Credit Guar		Universal			
Hospita	l, Chippenham SN15 2AJ	egory is ticked th	the patient will automatically be charged					

