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SPECIAL CARE DENTAL REFERRAL FORM

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

Mr Mrs Ms Miss *(delete as required)*			
First Name			
Surname			
Date of Birth		NHS Number	
Landline		Mobile	
Home Address			Postcode
Current Address *(if different from above)*			Postcode

Dentist Name			
Dentist Address			
		Tel:	
Doctor Name			
Doctor Address			
		Tel:	

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.*

Reason for referral & brief history of dental problem:

Referrer Name *(please print)*
Signature of Referrer
Position of Referrer
Contact Address
Tel:

Please print this form and post to:
Referral Department, Special Care Dental Service, 49 Rowden Hill, Community Hospital, Chippenham SN15 2AJ

Incomplete referrals will not be processed and will be returned to referrer and delay patient treatment

- Surgery care ensures the best and safest treatment
- SCDS surgeries are equipped with lifts and hoist to aid access
- Treatment options may be limited during domiciliary care
- Domiciliary care is only appropriate where patient is truly house bound or bed bound
- Environmental risk assessment may prevent domiciliary care being offered

Referral Date	

Patient / family carer aware of referral	Yes / No
Patient aware SCDS not responsible for emergency care before first appointment	Yes / No

Does patient have capacity to consent to treatment	Yes / No
If **NO** please complete box below	

Best Interest/Next of Kin Contact Details	
Name	
Address	
Tel. No.	
Email	
Relationship to patient	

Mobility Assessment *Tick as appropriate*

No mobility problems	☐	Sitting balance	☐
Hoist transfer	☐	Someone could escort them to Dental Surgery	☐
Attends Doctor Surgery or other appointment outside their home	☐	Able to weight bear	☐
		Wheelchair user	☐
Is truly house/bed bound	☐	Could attend Dental Surgery if transported by car / taxi / ambulance	☐
Transfer with aids	☐		

Category of Exemption *Tick as appropriate*

Pays Dental Charges ☐

If no category is ticked the patient will automatically be charged the standard NHS Dental Charges

Possible category of exemption

Income support	☐	Name on a valid HC2 Certificate	☐
Income based job seekers allowance	☐	Name on a valid NHS Tax Credit	☐
Income related employment & Support Allowance	☐	Reduced cost apply if named on HC3	☐
Pension credit Guarantee Credit	☐	Universal Credit	☐

SPECIAL CARE DENTAL REFERRAL FORM

CHILD (Under 18 years) *For Data Protection reasons this form should* ***not*** *be emailed*

Male Female *(delete as required)*			
First Name			
Surname			
Date of Birth		NHS Number	
Landline		Mobile	
Home Address			Postcode
Current Address *(if different from above)*			Postcode

Incomplete referrals will not be processed and will be returned to referrer and delay patient treatment

- Subject to patient meeting criteria for Special Care Dental Service (SCDS) patient will be offered an assessment
- Treatment will not normally be offered on this first appointment
- Until the first appointment with SCDS, the practice remains responsible for emergency care of the patient

Referral Date	

Dentist Name		
Dentist Address		
	Tel:	
Doctor Name		
Doctor Address		
	Tel:	

Patient / family carer aware of referral	Yes / No
Patient aware SCDS not responsible for emergency care before first appointment	Yes / No
Does this person have parental responsibility	Yes / No

Name of Primary Carer		Patient Ethnicity	
Relationship to patient			
Professionals involved in Child's Care (e.g. Social Worker). Name and contact details required.			
Language or Method of Communication			
School / Nursery attended by Child			
Contact details for school nurse			
Names of other children within the family home *(full names and DoB)*			

Referrer Name *(please print)*
Signature of Referrer
Position of Referrer
Contact Address
Tel:

Please print this form and post to:
Referral Department, Special Care Dental Service, 49 Rowden Hill, Community Hospital, Chippenham SN15 2AJ

Mobility Assessment *Tick as appropriate*

No mobility problems	☐	Sitting balance	☐
Hoist transfer	☐	Able to weight bear	☐
Transfer with aids	☐	Wheelchair user	☐

Current Medication & Relevant Medical History: *(attach print out if available or continue on separate sheet if required)*

Reason for referral & brief history of dental problem:

SPECIAL CARE DENTAL REFERRAL FORM

ADULT able to attend clinic *For Data Protection reasons this form should* ***not*** *be emailed*

Mr Mrs Ms Miss *(delete as required)*			
First Name			
Surname			
Date of Birth		NHS Number	
Landline		Mobile	
Home Address			Postcode
Current Address *(if different from above)*			Postcode

Dentist Name			
Dentist Address			
		Tel:	
Doctor Name			
Doctor Address			
		Tel:	

Current Medication & Relevant Medical History: *(attach print out if available or continue on separate sheet if required)*

Reason for referral & brief history of dental problem:

Referrer Name *(please print)*
Signature of Referrer
Position of Referrer
Contact Address
Tel:

Please print this form and post to:
Referral Department, Special Care Dental Service, 49 Rowden Hill, Community Hospital, Chippenham SN15 2AJ

Incomplete referrals will not be processed and will be returned to referrer and delay patient treatment

- Subject to patient meeting criteria for Special Care Dental Service (SCDS) patient will be offered an assessment
- Treatment will not normally be offered on this first appointment
- Until the first appointment with SCDS, the Dental Practice remains responsible for emergency care of the patient

Referral Date	

Patient / family carer aware of referral	Yes / No
Patient aware SCDS not responsible for emergency care before first appointment	Yes / No

Does patient have capacity to consent to treatment	Yes / No
If **NO** please complete box below	

Best Interest/Next of Kin Contact Details	
Name	
Address	
Tel. No.	
Email	
Relationship to patient	

Mobility Assessment *Tick as appropriate*

No mobility problems	☐	Sitting balance	☐
Hoist transfer	☐	Able to weight bear	☐
Transfer with aids	☐	Wheelchair user	☐

Category of Exemption *Tick as appropriate*

False declaration will incur a financial penalty from BSA

Pays Dental Charges	☐	Names on a valid HC2 Certificate	☐
Income Support	☐	Names on a valid NHS Tax Credit	☐
Income based Job Seekers Allowance	☐	Exemption Card	☐
Income related Employment & Support Allowance	☐	Reduced cost apply if named on HC3	☐
Support Allowance	☐	Certificate that is valid during course of treatment	☐
Pension Credit Guarantee Credit	☐	Universal Credit	☐

If no category is ticked the patient will automatically be charged