Great Western Hospitals NHS
NHS Foundation Trust

GUIDELINES FOR REFERRAL TO THE SPECIAL CARE DENTAL SERVICE IN WILTSHIRE AND SWINDON

This guide is intended to assist with the appropriate referral of patients to the Special Care Dental Service

Great Western Hospitals NHS Foundation Trust
Dental Admin Office
49 Rowden Hill
Chippenham Community Hospital
Chippenham
Wiltshire
SN15 2AJ
01249 456 597

Referrals

Referrals are accepted from:

General Dental Practitioners
General Medical Practitioners
Any other Health or Social Care Professional

Referrals are not accepted for:

Routine treatment on fit / healthy patients, or those that fall outside the categories below.
Such patients will be returned to the referring health care professional. To avoid unnecessary inconvenience for patients, please do not refer inappropriately.

Referrals

Referrals must be made on the appropriate forms provided, as this will give us the information we need to care for the patient in an appropriate and timely manner. Referrals received which are not on the official referral form or which are incomplete will be returned to the referrer.

Whenever possible, recent radiographs (taken within the last 12 months) should accompany the referral.

Referrals should be sent to Referrals Department, Great Western Hospitals NHS Foundation Trust, Dental Services, 49 Rowden Hill, Chippenham Community Hospital , Rowden Hill, Chippenham, Wiltshire, SN15 2AJ

Until the first appointment with the Special Care Dental Service, the practice remains responsible for emergency care of the patient.

Treatment for Adults

Referrals are accepted for adults who because of the severity of their additional needs are unable to be treated in a General Dental Practice setting. This may include but is not limited to:

Referrals are accepted for:

- Adults under the care of the local Mental Health Team
- Profound Learning Disabilities
- Severe Autistic Spectrum Disorders
- Dementia/Alzheimer's
- After Head and Neck Radiotherapy
- Domiciliary Care for Housebound Patients
- Severe Physical Disabilities
- Brain Injuries
- Life Limiting Conditions.

Referrals for all patients of 18 years and over should be sent on the adult referral form.

Referral for a Domiciliary Visit:

Domiciliary care is considered appropriate if the patient is truly bedbound or housebound that prevents them from attending the Surgery. Surgery care ensures that the best and safest treatment is provided.
All our special care dental surgeries have been assessed and are suitable for access as required by the Disability Act.
Please see page 4 for the list of our surgeries and the services available.

Referrals are not accepted for:

- Routine treatment for adults, unless they meet special care criteria
- Adult patients with dental phobias
- Adults with blood-borne viruses
- Adult patients on the basis of financial or geographic reasons
- Patients who are requesting but do not need a domiciliary
- We do not have facilities for treatment of bariatric patients.

Treatment for Children

Referrals are accepted for:

Referrals are accepted for children who because of the severity of their additional needs are unable to be treated in a General Dental Practice setting. This may include but is not limited to:: -

- Profound Learning Disabilities
- Severe Autistic Spectrum Disorders
- Severe physical disabilities
- Children with significant craniofacial anomaly affecting the teeth and jaws
- Children under the age of 5 with extensive decay for whom treatment has proved unsuccessful
- Looked After Children and those under a Child Protection Plan

Referrals for all patients from 0-18 years should be sent on form Appendix A (Under 18s). Incomplete forms will not be accepted and will be returned to the referrer.

Referrals are not accepted for:

- Routine treatment for children, unless they meet special care criteria
- Orthodontic extractions
- Children who require general anaesthesia, who should be referred direct to a local District General Hospital
- Children with dental phobias, who should be referred to local GDS practices willing to provide sedation
- Children with extensive treatment needs above the age of 5 years.

Exemptions and Remissions

It is imperative that it is identified prior to the patients' appointment whether they are exempt from dental charges. Failure to advise the service with this information may result in dental treatment being delayed and the referral being returned to the referrer.

If no category is identified patient will be charged standard NHS charges.

Exemption Entitlement	Category
Under 18	A
18 years of age and in full time education	B
Pregnant or a mother who has had a baby in the previous 12 months	C
Currently in a Prison or Young Offenders Institute	D
Income Support *(Incapacity & Disability Living Allowance do NOT count)*	E
Income-based Jobseekers Allowance *(Contribution-based does NOT count)*	F
Income-based Employment & Support Allowance *(Contribution-based does not count)*	G
Pension Credit Guarantee Credit *(Savings Credit on its own does NOT count)*	H
Named on a valid HC2 Certificate	I
Named on a valid NHS Tax Credit Exemption Certificate *(Card)*	J
Reduced costs apply if named on a HC3 Certificate that is valid during the course of treatment	K
Universal Credit *(Contribution-based does not count)*	L

These are the ONLY benefits that will entitle a patient to free dental services.

Other benefits such as Council Tax Benefit, Housing Benefit, Receipt of State/ Private Pension, NHS Prescription Charge Medical Exemption Certificate or any other benefits do not count.

The Business Services Authority will levy a fine for false declaration of exemption.

Great Western Hospitals NHS Foundation Trust – DENTAL SERVICE CLINICS

Clinic	Telephone	Services Available
Special Care Dental Service Chippenham Community Hospital Rowden Hill, Chippenham SN15 2AJ	**01249 456415**	Wheelchair Access Hoist Ground Floor
Dental Access Centre Chippenham Community Hospital Rowden Hill, Chippenham SN15 2AJ	**01249 456633**	Wheelchair Access Hoist Ground Floor
Devizes Community Hospital, New Park Road, Devizes SN10 1EF	**01380 725089**	Wheelchair Access Hoist Ground Floor
Salisbury, Central Health Clinic, Avon Approach, Salisbury SP1 3SL	**01722 322405**	Wheelchair Access Hoist 1st Floor Lift Access
Swindon NHS Health Centre 1 Islington Street, Swindon, SN1 2DQ	**01793 607850**	Wheelchair Access Hoist Ground Floor
West Swindon Health Centre, Link Avenue, White Hill Way, Swindon SN5 7BL	**01793 889428**	Wheelchair Access Hoist Lift

Please note that referrals should only be sent to Great Western Hospitals NHS Foundation Trust, Dental Services, Chippenham Community Hospital and not directly to the clinic.

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

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 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	☐		
Transfer with aids	☐	Could attend Dental Surgery if transported by car / taxi / ambulance	☐

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	☐

Referral pathway to Special Care Dental Service