**Please complete and send to:**

**Taunton:**

**Restorative Department, Musgrove Park Hospital, Parkfield Dr, Taunton TA1 5DA Tel: 01823 342 054/170**

**Email:** restorativereferrals.mph@somersetft.nhs.uk

**Bristol:**

**Patient Access Team, Bristol Dental Hospital, Lower Maudlin St, Bristol, BS1 2LY Tel: 0117 3424422**

**Plymouth:**

**Department of Restorative Dentistry, University Hospital Plymouth, Devon PL6 8DH Tel: 01752 763220/1**

**Email:** plh-tr.restorativedentistry@nhs.net

|  |
| --- |
| **PATIENT DETAILS** |
| **Surname: …………………………………….……………… First name: ……………………..……………… Date of Birth: ………………….………** |
| **REFERRAL INFORMATION** |
| [ ] Maxillary Denture [ ] Mandibular Denture [ ] Both *(please tick)* |
| **PLEASE TICK TO CONFIRM TREATMENT OF PRIMARY DENTAL DISEASE HAS BEEN COMPLETED?** [ ] Yes [ ] No Reason if No……..………………………………………………. |
| **TRIAGE INFORMATION** |
| Is this referral for: *(please tick)***A) Specialist Opinion Only?**[ ]  **B) Specialist Opinion and Treatment?** [ ]   |
| **Would (you be happy for) the patient be happy, to be treated at the Hospital as part of PG training?**  [ ] Yes [ ] No **Has the patient received treatment in a SW hospital dental department before?** [ ] Yes [ ] No  |
| **RADIOGRAPH** |
| Is a diagnostically acceptable **RADIOGRAPH** included with this referral? | [ ] YES [ ] NOReason if not……..………………………………………………. |
| **CLINICAL INFORMATION** |
| **CLINICAL REASON FOR REFERRAL.**  Please detail reason for referral and what you want us to do for your patient. |
| **RELEVANT PREVIOUS TREATMENT HISTORY.** Please detail. |
| **Standing teeth:**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 8 | 7 | 6 | 5 | 4 | 3 | 2 | 1 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| 8 | 7 | 6 | 5 | 4 | 3 | 2 | 1 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |

**Edentulous?** [ ] YES [ ] NO  | BPE Score:

|  |  |  |
| --- | --- | --- |
|  |  |  |
|  |  |  |

 |
| **ADDITIONAL INFORMATION** |
| **MEDICAL HISTORY -** Please include significant hospitalisation, operations, ongoing treatment and smoking/drinking history as needed. **YES** [ ]  please detail. **NONE** [ ]  |
| **MEDICATION -** Please state type and dosage details. **YES** [ ]  please detail. **NONE** [ ]  |
| **SMOKER/VAPOUR/EX SMOKER YES** [ ]  Number of years and number per day. **NO** [ ] *(delete as required)* |
| **ALLERGIES -** Please state allergy and description of reaction, if known. **YES** [ ]  please detail. **NONE** [ ]  |
| **OTHER INFORMATION** (E.g. Living arrangements, Legal guardian) |
| **FULL PATIENT DETAILS** | **REFERRER DETAILS** |
| Mr [ ]  Mrs [ ]  Miss [ ]  Ms [ ]  Dr [ ]  Other [ ] Male [ ]  Female [ ]  NHS Number:Surname:First name:Date of Birth:Address:Town/City:Postcode:Telephone Number:Mobile Number:E-mail Address: | Mr [ ]  Mrs [ ]  Miss [ ]  Ms [ ]  Dr [ ]  Other [ ] Surname:First name:Job Title:GDC Number:Practice Name:Practice Address:Town/City:Postcode:Telephone Number:E-mail Address: |
| **PATIENT GMP DETAILS** | **COMMUNICATION & SPECIAL REQUIREMENTS** |
| Practice Name:Practice Address:Town/City:Postcode:Telephone Number:E-mail Address: | Does the patient communicate in a language or mode other than English? YES [ ]  please detail. NO [ ] Is an interpreter required? YES [ ]  please detail. NO [ ] Does the patient have any special requirements? YES [ ]  please detail. NO [ ]  |
| **PATIENT CONSENT TO REFERRAL AND ASSOCIATED TREATMENT** |
| Has the patient understood and consented to the referral and is happy (if accepted) for treatment to be delivered by oral health care professionals undergoing training?YES [ ]  NO [ ]  |
| **ACCEPTANCE CRITERIA** |
| The following priority groups are considered appropriate for referral for advice and, if necessary, specialist treatment:1. Head and Neck Oncology patients2. Development defect, such as cleft lip and palate; hypodontia; and complex dental anomalies3. Trauma: severe trauma involving the dentoalveolar complexOther referrals might be accepted by a teaching hospital for training needs;1. Previous attempts to make a satisfactory denture2. Complex anatomyProviding the medical history does not dictate otherwise, the following are not considered appropriate reasons for referral:1. Untreated caries2. Untreated periodontal disease3. Patients who cannot or will not pay NHS or private charges |
| **CONFIRMATION AND SIGNATURE OF REFERRING PRACTITIONER** |
| *I confirm that this patient referral meets the current referral guidelines as issued by the South West MCN.**I understand that incomplete and/or inappropriate referrals will be returned for revision and may delay patient treatment.**Please tick to confirm.* [ ]  |
| **Print Full Name:………………………………………………………………………………………………… Date:………………………….................****Signature: ………………………………………………………………………………** |