**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](mailto: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](mailto:plh-tr.restorativedentistry@nhs.net)

|  |  |  |
| --- | --- | --- |
| **PATIENT DETAILS** | | |
| **Surname: …………………………………….……………… First name: ……………………..……………… Date of Birth: ………………….………** | | |
| **REFERRAL INFORMATION** | | |
| Primary RCT Re-RCT Periradicular Surgery Suspected Perio-Endo lesion *(please tick)* | | |
| **IS THE TOOTH RESTORABLE?** Yes 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 NO  Reason 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. | | |
| **WHY IS THE TOOTH IMPORTANT?** *(please tick)*  Appearance Strategic (e.g. abutment tooth) Occlusal stability Function | | |
| **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 | | **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** | | |
| Cases will be considered for acceptance based on the following criteria;   * If the patient has a stable oral environment * The tooth/teeth which require treatment are of strategic importance and can be made predictably functional with a favourable prognostic success rate * The following priority groups are also considered appropriate for referral for advice and, if necessary, treatment:   + Head and Neck Oncology patients   + Development defect, such as cleft lip and palate; hypodontia; and complex dental anomalies   + Trauma: severe trauma involving the dentoalveolar complex   Patients will not be offered treatment if:  1. They have an unstable oral environment i.e. poor oral health, active caries and/or active periodontal disease  2. They are “keen to save” the tooth/teeth but the prognosis is considered poor  3. The tooth is a second or third molar unless it is of strategic value to the overall treatment plan  4. They require sedation or GA for routine dental treatment. | | |
| **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: ………………………………………………………………………………** | | |