**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

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| --- |
| **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:**

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

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| **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 disease2. They are “keen to save” the tooth/teeth but the prognosis is considered poor3. The tooth is a second or third molar unless it is of strategic value to the overall treatment plan4. 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: ………………………………………………………………………………** |