**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** |
| All patients should only be referred after they have received the following treatment from the referring Oral Healthcare Professional Tick to confirm:[ ] Oral Hygiene Instruction (OHI) including interdental cleaning[ ] 6 point pocket charting (When BPE of 3/4 is recorded then an appropriate 6PPC must be included for the referral to be accepted. Referrals will be rejected if 6PPC chart is not included and BPE is 3 or higher.)[ ] Non-surgical root surface debridement (RSD) [ ] Treatment Under Local Anaesthetic[ ] A monitoring visit to assess the response to OHI and RSD[ ] Where appropriate, patients who smoke should be encouraged to cease the habit on the basis that treatment outcome is often poorFollowing completion of the treatment plan and lack of periodontal stability, we may consider the referral. |
| **PLEASE TICK TO CONFIRM CARIES HAS BEEN MANAGED FOR STABALISATION PRIOR TO REFERRAL?** Yes [ ]  No [ ] Reason if not……..………………………………………………. |
| **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** |
| **REASON FOR REFERRAL.**  Please detail reason for referral and what you want us to do for your patient. |
| **RELEVANT TREATMENT HISTORY.** Please detail. |
| **STAGE (1-4) OF PERIODONTITIS** |  | **Grade (A-C) OF PERIODONTITIS** |  |
| **DIABETES?** Yes [ ]  No [ ]  | **IF YES, CONTROL LEVEL?** |  |
| **FAMILY HISTORY OF PERIODONTITIS?** Yes [ ]  No [ ]  |
| **SMOKER/VAPOUR/EX SMOKER YES** [ ]  Number of years and number per day. **NO** [ ] *(delete as required)* |
| **BPE Score:**

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| **MEDICAL HISTORY/SOCIAL DETAILS** |
| **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** [ ]  |
| **ALLERGIES -** Please state allergy and description of reaction, if known. **YES** [ ]  please detail. **NONE** [ ]  |
| **OTHER INFORMATION** (E.g. Living arrangements, Legal guardian) |
| **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 [ ]  |
| **FULL PATIENT DETAILS** | **(GDP) 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 [ ]  |
| **ACCEPTANCE CRITERIA** |
| **General Principles*** Dental Practitioners are responsible for explaining to the patient the exact reason for the referral. The patient should understand that an explanation of the problem will be given but they may not be accepted for treatment at the hospital.
* Referred patients should understand that they may be offered treatment as part of a teaching programme.
* Referred patients should maintain contact with the referring Dental Practitioner to whom they will return for maintenance/supportive periodontal care.

**The following patients may also be referred:*** Patients with recurrent acute necrotising ulcerative gingivitis/periodontitis, non-plaque related gingival/periodontal conditions, localised gingival recession or medication associated gingival enlargement may be referred.
* Patients considered to require mucogingival surgery (for recession) may be referred.
* Patients with endo-perio conditions

**Non-Acceptance Guidelines:*** The following categories of patient should NOT be referred:
* Irregular attenders in general dental services.
* Those unwilling or unable to meet NHS or private charges for treatment as the main basis for referral.
* Those who have continual poor oral hygiene.
* Those with active periodontal disease who have not received the expected initial periodontal treatment outlined above.

**Discharge from the Care Network*** All periodontal patients will be discharged back to their own Dental Practitioner for supportive periodontal therapy.
* Re-referral of patients should not be made if disease recurrence results from a failure to comply with OHI or a lapse in oral hygiene without this being rectified by the General Practitioner or Practice Hygienist.
* Smokers whose treatment response has been poor may be re-referred if they make substantial effort to reduce the habit.
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| **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: ………………………………………………………………………………** |