**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** | | |
| **Date of referral: ………………….………**  Tooth surface loss Dental Trauma Pain Diagnosis  Hypodontia Cleft Tooth Structure Abnormality Oncology  Other **……………………………….……………………………………………….………………** *(please tick)* | | |
| **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** | | |
| **CLINICAL INFORMATION** | | |
| **REASON FOR REFERRAL.**  Please detail reason for referral and what you want us to do for your patient. | | |
| **PROVISIONAL DIAGNOSIS.** | | |
| **TREATMENT HISTORY.** Please detail | | |
| **Standing teeth:** *please circle 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:**   |  |  |  | | --- | --- | --- | |  |  |  | |  |  |  | | |
| **RADIOGRAPH** | | |
| Is a diagnostically acceptable **RADIOGRAPH** included with this referral? | YES  NO Reason if not……..………………………………………………. | |
| **MEDICAL HISTORY/SOCIAL DETAILS** | | |
| **MEDICAL HISTORY -** Please include significant hospitalisation, operations, ongoing treatment and smoking/drinking history as needed. **YES**  please detail. **NONE** | | |
| **MEDICATION LIST -** Please state type and dosage details. Or attached prescription. **YES**  please detail. **NONE** | | |
| **ALCOHOL COMSUMPTION YES**  Number of units a week. **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** | | **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 |
| **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 patients  2. Development defect, such as cleft lip and palate; hypodontia; and complex dental anomalies  3. Trauma: severe trauma involving the dentoalveolar complex  Other referrals might be accepted by a teaching hospital for training needs.  It should be noted that providing the medical history does not dictate otherwise, the following are not considered appropriate reasons for referral:   1. Untreated caries 2. Untreated periodontal disease 3. Manufacture of soft and hard acrylic occlusal guards 4. Patients who cannot or will not pay NHS or private charges 5. Primary or secondary RCT in patients who are not in priority groups 6. Where the long-term restorability or periodontal prognosis of the tooth is in question. 7. Patients with anxiety who required sedation or general anaesthetic. | | |
| **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: ………………………………………………………………………………** | | |