For adults aged 16 and over. Please see published Special Care Dental Referral criteria.

**Please return fully completed forms to:**

Patient Access Team, Bristol Dental Hospital, Chapter House, Lower Maudlin Street, Bristol, BS1 2LY.

Telephone: 0117 342 4422.

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| **PATIENT DETAILS** | | | |
| **Surname: …………………………………….……………… First name: ……………………..……………… Date of Birth: ………………….………** | | | |
| **REFERRAL INFORMATION** | | | |
| **URGENT ☐** **ROUTINE** **☐** | | | |
| Is this referral for: **A) Specialist Opinion Only?** **☐** OR **B) Specialist Opinion and Treatment?** **☐** *(please tick)* | | | |
| **RADIOGRAPH** | | | |
| Is a diagnostically acceptable **RADIOGRAPH** included with this referral? | | YES ☐NO ☐Reason if not……..……………………………………………. | |
| **CLINICAL INFORMATION** | | | |
| **Clinical reason for referral of this patient:**  *What dental treatment does the patient need?* | | | |
| **Past Dental History:**  *What treatment has been attempted and what difficulties were encountered?* | | | |
| **MEDICAL HISTORY** | | | |
| **MEDICAL HISTORY**  *Please include significant hospitalisation, operations, ongoing treatment and smoking/drinking history*  *Please include if the patient is under any other medical specialities* | | | |
| **MEDICATION** YES ☐ NONE ☐  *Please list all medications being taken, including any current or previous intravenous or infusion medication* | | | |
| **ALLERGIES**  YES ☐ NONE ☐  *Please state allergy and description of reaction, if known* | | | |
| **ADDITIONAL INFORMATION Please give details** | | | |
| **Ability to communicate?** | Unimpaired. ☐  Partial impaired ☐  Severely impaired ☐  **Interpreter required** ☐ | | *Language spoken if interpreter required:* |
| **Mobility** | Wheelchair user ☐  Stretcher user ☐ | |  |
| **Are they able to weight bear for transfer to the dental chair?** | Yes ☐  No ☐ | |  |
| **Will the patient require hospital transport?** | Yes ☐  No ☐ | |  |
| **Is there any doubt about capacity to consent?** | Yes ☐  No ☐ | |  |
| **Does the patient weigh over 23 stone?** | Yes ☐  No ☐ | | *Weight if over 23 stone:* |
| **Any other special requirements?**  *Please detail:* | | | |

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| --- | --- |
| **FULL PATIENT DETAILS** | **PATIENT’S NEXT OF KIN** |
| Mr **☐** Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Other ☐  Male ☐ Female ☐ Other ☐ NHS Number:  Surname:  First name:  Date of Birth:  Address:  Town/City:  Postcode:  Telephone Number:  E-mail Address: | Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Other ☐  Relationship to patient:  Surname:  First name:  Date of Birth:  Address:  Town/City:  Postcode:  Telephone Number:  E-mail Address: |
| **REFERRER DETAILS** | **PATIENT GMP DETAILS** |
| Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Other ☐  Surname:  First name:  Job Title:  GDC/GMC Number:  Practice Name:  Practice Address:  Town/City:  Postcode:  Telephone Number:  E-mail Address: | Surname:  First name:  Practice Name:  Practice Address:  Town/City:  Postcode:  Telephone Number:  E-mail Address: |
| **PATIENT CONSENT TO REFERRAL** | |
| Has the patient/ carer understood and consented to the referral? YES ☐ NO ☐ | |
| **ACCEPTANCE CRITERIA** | |
| **Acceptance Criteria – please note we only accept Adult patients (age 16 and above)**  *(Children with additional needs need to be referred to either the Primary Care dental service/ Paediatric dental department at BDH)*  The following priority patient groups will be considered for acceptance for opinion/treatment:   * Patients with unstable medical conditions (ASA III/IV), and where care cannot be safely provided in Primary Care Services. * Patients with severe learning disabilities or dementia (24/7 care) where dental treatment cannot be carried out in Primary Care (may require general anaesthetic (GA) or sedation). * Patients with complex medical conditions, where dental management requires close liaison with medical specialties, where this is not possible in primary care (e.g. patients with moderate/ severe haemophilia). * Patients with severe physical, neurological and/or movement disabilities (e.g. Cerebral palsy, Parkinson’s disease), where treatment is not possible in primary care. * Adults with complex behavioural and psychiatric problems: Uncontrolled, unstable mental health issues, this may include risk of harm to healthcare workers, and require sedation/ GA for dental treatment. * Bariatric patients: patients who exceed the safe weight limit of dental chair and may require use of the Bariatric dental chair (those weighing over 23 stone), and have medical problems which cannot be managed in primary care (e.g. limited mobility, large wheelchairs or difficulty transferring to the dental chair). * Patients with complex needs who require comprehensive dental treatment under General Anaesthesia e.g. patients with profound learning disabilities (and occasionally, patients with severe mental ill health or physical disabilities) who cannot be managed appropriately with local anaesthesia or sedation. * Patients who have a proven, or suspicion of, immediate Type I allergic reaction to substances that may affect the provision of dental care, e.g. natural rubber latex, where the patient may develop a life-threatening anaphylaxis.   We would ask that GDPs looking to refer to Special Care Dentistry consider a referral to Primary Care Dental services (PCDS) in the first instance if appropriate. | |
| **CONFIRMATION AND SIGNATURE OF REFERRING PRACTITIONER** | |
| I confirm that this patient referral meets the current referral guidelines as issued by the Bristol Dental Hospital. (Referral guidelines are available on the BDH website). 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: ……………………………………………………………………………… | |