Taunton Referrals: Email: [restorativereferrals.mph@somersetft.nhs.uk](mailto:restorativereferrals.mph@somersetft.nhs.uk)

Plymouth Referrals: Email: [plh-tr.restorativedentistry@nhs.net](mailto:plh-tr.restorativedentistry@nhs.net)

Bristol Referrals: Patient Access Office, Bristol Dental Hospital, Lower Maudlin Street, Bristol, BS1 2LY

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Section1: REFERRAL INFORMATION** | | | | |
| Please note:   * If your referral does not meet the required criteria or if this form is not legible or completed fully, we reserve the right to return it to you. * All attachments **MUST** be included for your referral to be accepted. * If the patient is accepted for a course of treatment this does not mean they will receive ongoing care on completion of the treatment and emergency appointments should be addressed by GDP. | | | | |
| 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 poor  Following 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……..………………………………………………. | | | | |
| **Section2: TRIAGE INFORMATION** | | | | |
| Is this referral for: *(please tick)*  **A) Specialist Opinion Only?**  **B) Specialist Opinion and Treatment?** | | | | |
| **Would you/the patient be happy, to be treated at the Hospital as part of Post Graduate training (DCP or Dentist)?**  Yes No  **Has the patient received treatment in a hospital dental department before?**  Yes No | | | | |
| **Section 3: RADIOGRAPH** | | | | |
| Is a diagnostically acceptable **RADIOGRAPH** included with this referral?  Yes  No Reason if not……..………………………………………………. | | | | |
| **Section 4: 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. | | | | |
| **Section 5:**  **STAGE (1-4) OF PERIODONTITIS** |  | **Section 6:**  **Grade (A-C) OF PERIODONTITIS** | |  |
| **DIABETES?**  Yes  No | | **If YES, Type and Hb1AC or level of control?** | |  |
| **FAMILY HISTORY OF PERIODONTITIS?**  Yes  No | | | | |
| **SMOKER/VAPER/EX SMOKER** *(delete as required)*  Yes  Number of years and number per day. No | | | | |
| **BPE Score:**   |  |  |  | | --- | --- | --- | |  |  |  | |  |  |  | | | | | |
| **Section 7: MEDICAL HISTORY/SOCIAL DETAILS** | | | | |
| **MEDICAL HISTORY -**  Please include significant hospitalisation, operations, ongoing treatment and smoking/drinking history as needed.  Yes  please detail. N/a | | | | |
| **MEDICATION -** Please state type and dosage details.  Yes  please detail. N/a | | | | |
| **ALLERGIES -** Please state allergy and description of reaction, if known.  Yes  please detail. No Known Allergies | | | | |
| **SOCIAL HISTORY AND OTHER INFORMATION** (E.g. Living arrangements, Legal guardian) | | | | |
| **Section 8: PATIENT CONSENT TO REFERRAL AND ASSOCIATED TREATMENT** | | | | |
| The patient has been told about referral guidelines and understands opinion only service provided if not in a dental priority group. They have consented to this referral and are aware all their dental concerns/needs still need to be managed in primary care.  Yes  No | | | | |
| **Section 9: FULL PATIENT DETAILS** | | | **Section 10: (GDP) REFERRER DETAILS** | |
| NHS Number:  Mr  Mrs  Miss  Ms  Dr  Other  Gender:  Surname:  First name:  Date of Birth:  Address:  Town/City:  Postcode:  Telephone Number:  Mobile Number:  E-mail Address: | | | GDC Number:  Mr  Mrs  Miss  Ms  Dr  Other  Surname:  First name:  Job Title:  Practice Name:  Practice Address:  Town/City:  Postcode:  Telephone Number:  Mobile Number:  E-mail Address: | |
| **Section 11: PATIENT GMP DETAILS** | | | **Section 12: 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 require any reasonable adjustments? Yes  please detail. No | |
| **Section 13: 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. | | | | |
| **Section 14: 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:** | | | | |