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| --- | --- | --- | --- | --- | --- |
| **SECTION 1: REFERRAL INFORMATION** | | | | | |
| **Type of referral: URGENT**  **ROUTINE**     |  |  |  |  | | --- | --- | --- | --- | | GA Assessment | Consultant New Patient Clinic | MDT (Paediatrics / Ortho) | Trauma | | Primary Dentition | Permanent | Mixed | Age of patient at time of referral | | Inhalation Sedation | General Anaesthetic |  | |   **Justification for general anaesthetic:**  ***May we remind you of The Maintaining Standards guidelines which state that:***  *Clear justification for the use of general anaesthesia together with the details of the relevant medical and dental histories of the patient must be contained in this referral document. The referring dentist must retain a copy of this. Paragraph 4.18 GDC Maintaining Standards, revised November 2001* | | | | | |
| **SECTION 2: PATIENT DETAILS** | | | **SECTION 3: PERSON WITH PARENTAL RESPONSIBILITY** | | |
| **First Name:** |  | | **First Name:** |  | |
| **Surname:** |  | | **Surname:** |  | |
| **Address:**  **Post code:** |  | | **Address:**  **Post code:** |  | |
| **Home Tel No:** |  | | **Home Tel No:** |  | |
| **Mobile No:** |  | | **Mobile No:** |  | |
| **Date of Birth:** |  | | **Relationship to Patient:** |  | |
| **Gender:** |  | | **Professionals involved in care**  **(e.g. paediatrician, social worker, learning disabilities team?)** *If yes, please give details*  **Name:**  **Contact Number:**  **Email:** | | |
| **School:** |  | |
| **Patients NHS No:** |  | |
| **Safeguarding Concerns (if applicable)**  **Looked After Child**    **Child Protection Plan in place** |  | |
| **SECTION 4: REFFERER DETAILS** | | | **SECTION 5: PATIENT GMP DETAILS** | | |
| **Name:** |  | | **Name:** | |  |
| **Address:** |  | | **Practice Address:** | |  |
| **Tel No:** |  | | **Practice Tel No:**  *If**known* | |  |
| **NHS.net email address**  *(or secure email address)* |  | |  | |  |
| **SECTION 6: REASON FOR REFERRAL AND TREATMENT ATTEMPTED IN PRACTICE** | | | | | |
|  | | | | | |
| **SECTION 7: ORAL HEALTH PREVENTION** | | | | | |
| Following treatment carried out prior to referral by:  Clinician  Therapist  Hygienist  DCP   |  |  | | --- | --- | | Oral Health Prevention | Yes  No | | Diet Advice given | Yes  No | | Fluoride Varnish Applied | Yes  No  Date of last application: \_\_/\_\_/\_\_\_\_ | | | | | | |
| **SECTION 8: PROVISIONAL DIAGNOSIS** **AND CURRENT TREATMENT PLAN IN ASSOCIATION WITH THIS REFERRAL. INCLUDE PREVIOUS TREATMENT HISTORY.** *Please* *detail what is required* | | | | | |
|  | | | | | |
| **SECTION 9: MEDICAL HISTORY – Referrer to complete** | | | | | |
| |  |  |  | | --- | --- | --- | | Has the child or anyone in the family had a problem with anaesthetic? | Yes | No | | Has the child had any previous operations or been in hospital for anything? | Yes | No | | Is the child under regular review or treatment at any hospital? | Yes | No | | Please specify below: | | |  |  |  |  | | --- | --- | --- | | Is the child allergic to anything? | Yes | No | | Is the child on the Autistic spectrum or have any additional needs? | Yes | No | | Is the child taking any medicines/tablets or injections (please specify below)? | Yes | No |   **Does the child have:**   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | Heart issues | Yes | No | Diabetes | Yes | No | | Asthma or chest problems | Yes | No | Bleeding disorders | Yes | No | | Liver disease or jaundice | Yes | No | Epilepsy or convulsions | Yes | No | | Kidney problems | Yes | No |  | | |      |  |  |  | | --- | --- | --- | | Is the child of Afro Caribbean, Eastern Mediterranean, or North African origin? | Yes | No | | If YES, do you know of their Sickle Cell / Thalassemia status | Yes | No | | | | | | |
| **SECTION 10: COMMUNICATION AND IDENTIFIED REASONABLE ADJUSTMENTS – *please detail communication, mobility or other reasonable adjustments required by the patient below*** | | | | | |
| Learning Disability  Autism Spectrum Disorder  Mental Health Condition  Hearing Impairment  Medical Disability  Wheelchair  Physical Disability  Visual Impairment | | | | | |
| **SECTION 11: RADIOGRAPHS – *please ensure all relevant and recent radiographs are enclosed for patient assessment.*** | | | | | |
| |  |  |  | | --- | --- | --- | | Radiographs enclosed | Yes | No | | DPT | Date taken:\_\_/\_\_/\_\_\_\_ | | | Intra Oral | Date taken:\_\_/\_\_/\_\_\_\_ | | | | None taken  *Please give reason for not providing radiographs*: | | | |
| **SECTION 12: ERUPTED CANINES for children aged 9 years +** | | | | | |
| Are the UPPER PERMANENT CANINES erupted / unerupted but palpable in correct (buccal) position over the age of 9 years?  Yes  No  If no, the canine may be ectopic. **PLEASE PROVIDE RADIOGRAPH** | | | | | |
| **SECTION 13: PERSON WITH PARENTAL RESPONSIBILITY CONSENT TO REFERRAL AND ASSOCIATED TREATMENT** | | | | | |
| Has the responsible adult understood and consented to the referral for the child or young person?  Yes  No | | | | | |
| **SECTION 14 – CONFIRMATION AND SIGNATURE OF REFERRING PRACTITIONER** | | | | | |
| I understand that incomplete and/or inappropriate referrals will be returned for revision and may delay patient treatment. Referral be signed by referring clinician only (electronic signature accepted).  Please tick to confirm. | | | | | |
| **Print GDP Full Name:………………………………………………………………………………………GDC Number:…………….................**  **GDP Signature: ………………………………………………………………………………................ Date:…..........................................** | | | | | |

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| --- | --- | --- | --- |
| **SECTION 15: TRIAGE OUTCOME** | | | |
| **Date triaged** |  | **Triaged by** *(please print full name and position)* | |
| **Referral accepted** | **Urgent**  **Routine**  **Indicated time span to be seen……….. wks** | **If rejected, please state reason why?** | |
| **Patent Complexity** | **Level 1** | **Level 2** | **Level 3** |