****

**South West Region**

**Special Care Dentistry Referral Form to Community Dental Services**

**Adults and Children**

**For referral by Dental Professionals only**

**Please note:**

* **If your referral does not meet the Special Care Dental Service criteria or if this form is not legible or completed fully, we reserve the right to return it to you.**
* **If the patient is accepted for a course of treatment this does not mean they will receive ongoing care on completion of the treatment.**
* **For Dorset referrals, please use the Vantage Rego DERS system**

|  |
| --- |
| **SECTION 1: REFERRAL INFORMATION** |
| **Type of Referral**  | Specialist Opinion only [ ]  Shared Care [ ]   | Specialist Opinion and Treatment [ ]   |
| **SECTION 2: PATIENT DETAILS** | **SECTION 3: PARENT/CARER/GUARDIAN INFORMATION** |
| **Name** |  | **Name** |  |
| **Address** | **Address** |
| **Home Tel. No.** |  | **Home Tel. No.** |  |
| **Mobile Number** |  | **Mobile Number** |  |
| **Email address**  |  | **Email address** |  |
| **Date of Birth** |  | **Relationship to patient** |  |
| **Nursery/School/College (if relevant)** | Professionals involved in care (e.g. social worker, learning disability team)? If yes, please give details **Yes** [ ]  **Details:** |
| **Gender** |  |
| **Patient’s NHS Number** |  |
| **Relevant Safeguarding information** |  |
| **SECTION 4: REFERRER DETAILS** | **SECTION 5: PATIENT GP DETAILS**  |
| **Name** |  | **Name** |  |
| **Practice Address** |  | **Practice Address** |  |
|  |  |  |  |
| **Tel. No.** |  | **Practice Tel. No.** |  |
| **NHS.net email address** |  | **NHS.net email address** |  |
| **SECTION 6: REASON FOR REFERRAL AND TREATMENT REQUESTED** |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Learning Disability | [ ]   | Autism Spectrum Disorder | [ ]   | Mental Health Condition | [ ]   |
| Medical Disability | [ ]   | Dementia | [ ]   | Physical Disability | [ ]   |

|  |
| --- |
| **Please explain why you are referring the patient and what treatment is required** |
| **SECTION 7: DESCRIBE PREVIOUS ATTEMPTS AT TREATMENT**Please explain what treatment has been attempted and why the patient cannot be treated within General Dental Practice |
|    |
| **SECTION 8: MEDICAL HISTORY**Please include an overview of the patient’s medical history, a copy of their medication list, any known allergies, a copy of the latest clinical letter or any other information that may be pertinent to their dental care |
|  |
| **SECTION 9: COMMUNICATION AND IDENTIFIED REASONABLE ADJUSTMENTS**Please detail communication, mobility or other reasonable adjustments required by the patient below |
|  |
| **SECTION 10: RADIOGRAPHS**Please ensure all relevant and recent radiographs are enclosed for patient assessment |
| **Radiographs enclosed**DPT [ ]  Intra Orals [ ]  Date taken:  | None [ ]  Please give reason for not providing radiographs)  |
| **SECTION 11: SIGNATURE** |
| **Print Name** |  | **Signature** |  |
| **GDC Number** |  | **Date** |  |
|  |  |  |  |

|  |
| --- |
| **SECTION 12: TRIAGE OUTCOME**  |
| **Date Triaged** |  | **Triaged by (print name and position)** |
| **Referral Accepted** |  | **If rejected, please state reason for rejection** |
| **Patient Complexity** | [ ]  Level 1 | [ ]  Level 2 | [ ]  Level 3 |

**Completed forms to be returned to the relevant provider:**

|  |  |
| --- | --- |
| **Area** | **Details** |
| Cornwall | ciosicb.rmsdentalreferrals@nhs.net |
| Plymouth | livewell.referralsplymouthcommunitydentistry@nhs.net |
| Torbay | sdc-dental.t-sd@nhs.net |
| Devon (excluding Plymouth and Torbay) | rduh.sds-referral@nhs.net |
| Somerset | scwcsu.dentalwest1@nhs.net |
| BNSSG & BaNES | primarycaredentalreferrals@uhbw.nhs.uk  |
| Wiltshire and Swindon | gwh.dentaladmin.teamoffice@nhs.net |
| Gloucestershire | <https://www.ghc.nhs.uk/our-teams-and-services/gloucestershire-specialist-dental-service/> |
| Dorset | [Vantage Rego (ref.management)](https://ref.management/login) |