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

**Plymouth Referrals:**  No Restorative Consultant available not accepting any new referrals until Sept 25.

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

**Torbay or Truro Referrals:** Limited acceptance. Not open to external referrals. Urgent dental priority group referrals considered on a case-by-case basis. Cover letter and completed referral document below required but acceptance is not guaranteed.

|  |  |  |
| --- | --- | --- |
| **ACCEPTANCE CRITERIA** | | |
| **The following priority groups are considered appropriate for referral for advice and, if necessary, treatment:**   * **Head and Neck Oncology patients** * **Development defect, such as cleft lip and palate; hypodontia; and complex dental anomalies** * **Trauma: severe trauma involving the dentoalveolar complex**   **Advice only is available to anyone who has complex restorative requirements (they will however not be eligible for treatment)** | | |
| **Section 1: REFERRAL INFORMATION (Please tick)** | | |
| **Restorative All referrals are for assessment and advice only unless patient falls into a priority group.**  Tooth surface loss  Dental Trauma  Pain Diagnosis  Hypodontia  Cleft  Tooth Structure Abnormality  Oncology  Other  *(please confirm in reason for referral)*  **Why is the tooth important?**  Appearance  Strategic *(**e.g. abutment tooth)*  Occlusal stability  Function | | |
| **Endo** **All referrals are for assessment and advice only unless patient falls into a priority group.**  Primary RCT  Re-RCT  Periradicular Surgery  Suspected Perio-Endo lesion    **Is the tooth restorable?** Yes  No  *(If No please detail why referral is being made in reason for referral section if related to MORNJ detail drug/delivery/frequency/length of time taken)*  **Why is the tooth important?**  Appearance  Strategic *(**e.g. abutment tooth)*  Occlusal stability  Function | | |
| **Denture All referrals are for assessment and advice only unless patient falls into a priority group.**  Maxillary Denture  Mandibular Denture  Both  **Please tick to confirm treatment of primary dental disease has been completed** Yes  No  **If No,** please give reason why in treatment history section. | | |
| **Section 2: TRIAGE INFORMATION** | | |
| Is this referral for: *(please tick)*  **A) Specialist Opinion Only?**  **B) Specialist Opinion and Treatment *(treatment is not guarantee and is subject to acceptance criteria)*?** | | |
| **Would you/the patient be happy, to be treated at the Hospital as part of Post Graduate training (DCPs or dentists)?**  Yes No  **Has the patient received treatment in a hospital dental department before?**  Yes *(Please give details)*No | | |
| **Section 3: RADIOGRAPH** | | |
| Is a diagnostically acceptable **RADIOGRAPH** included with this referral?  Yes  No  Reason if not……..………………………………………………. | | |
| **Section 4: CLINICAL INFORMATION *(all sections to be completed)*** | | |
| **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:**   |  |  |  | | --- | --- | --- | |  |  |  | |  |  |  | | |
| **Section 5: 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 LIST -** *Please state* ***reason****,* ***type*** *and* ***dosage*** *details. Local medical history can be attached if sufficient details are included.*  Yes please detail. N/A | | |
| **ALCOHOL CONSUMPTION**  **Yes**  Number of units a week. N/A | | |
| **SMOKER/VAPER/EX SMOKER** *(delete as required)*  **Yes**  Number of years and number per day. **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) | | |
| **Section6: FULL PATIENT DETAILS** | | **Section7: 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 8: PATIENT GMP DETAILS** | | **Section 9: 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 10: 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 11: REFERRAL INFORMATION** | | |
| * If your referral does not meet the required criteria or if this form is not legible or not 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. * To be accepted for treatment within the Hospital all patients should have a GDP who can support ongoing care. | | |
| **Section 12: ACCEPTANCE CRITERIA** | | |
| All referrals will only be considered appropriate for a referral if:   * If the patient has a stable oral environment * The tooth/teeth which require treatment are of strategic importance and are not of hopeless prognosis.   It should be noted that the following are NOT considered appropriate reasons for referral and patients will NOT be offered treatment if:   * They have an unstable oral environment i.e. poor oral health, active caries and/or active periodontal disease * They are “keen to save” the tooth/teeth but the prognosis is considered poor * The tooth is a second or third molar unless it is of strategic value to the overall treatment plan * They require sedation or GA for routine dental treatment. * Untreated caries or periodontal disease * Manufacture of soft and hard occlusal guards * Patients who cannot or will not pay NHS or private charges. * Primary or secondary RCT or dentures in patients who are not in priority groups. * Where the long-term restorability or periodontal prognosis of the tooth is in question. * Patients with anxiety who required sedation or general anaesthetic for non-specialist restorative dental treatment (this requires a referral to special care or community services). | | |
| **Section 13: 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:** | | |