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| **SECTION 1: REFERRAL INFORMATION**  |
| **Type of referral: URGENT** [ ]  **ROUTINE** [ ]

|  |  |  |  |
| --- | --- | --- | --- |
| General Anaesthetic [ ]  | Consultant New Patient Clinic [ ]  | MDT (Paediatrics / Ortho) [ ]  | Trauma[ ]  |
| Primary Dentition [ ]  | Permanent[ ]  | Mixed[ ]  | Age of patient at time of referral |
| Inhalation Sedation [ ]   |  |

**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:** |  |
| **Mobile No:** |  |
| **Home Tel No:** |  |
| **Email:** |  |
| **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)****Child in Care**[ ] **Child Protection Plan in place** [ ]  |  |
| **SECTION 4: CONTACT PREFERENCES - PARENT/GUARDIAN TO COMPLETE**  |
| I consent to be being contacted via the following method(s) regarding appointments/correspondence. Please tick to confirm your contact preferences. [ ]  EMAIL [ ]  TEXT [ ]  PHONE [ ]  LETTER |
| **Full Name: ………………………………………………………………………………................ Date:…..........................................** |

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| **SECTION 5: REFFERER DETAILS** | **SECTION 6: PATIENT GMP DETAILS** |
| **Name:** |  | **Name:** |  |
| **Address:** |  | **Practice Address:** |  |
| **Tel No:** |  | **Practice Tel No:** *If**known* |  |
| **NHS.net email address** *(or secure email address)* |  |  |  |
| **SECTION 7: REASON FOR REFERRAL AND TREATMENT ATTEMPTED IN PRACTICE**  |
|  |
| **SECTION 8: 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 9: PROVISIONAL DIAGNOSIS** **AND CURRENT TREATMENT PLAN IN ASSOCIATION WITH THIS REFERRAL. INCLUDE PREVIOUS TREATMENT HISTORY.** *Please* *detail what is required* |
|  |
| **SECTION 10: MEDICAL HISTORY – Referrer to complete** |
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| --- | --- | --- |
| 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 neurodiverse or do they 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 11: COMMUNICATION AND IDENTIFIED REASONABLE ADJUSTMENTS – *please detail communication, mobility or other reasonable adjustments required by the patient below*** |
| Learning Disability [ ]  Neurodiverse [ ]  Mental Health Condition [ ]  Hearing Impairment [ ] Medical Disability [ ]  Wheelchair [ ]  Physical Disability [ ]  Visual Impairment [ ]   |
| **SECTION 12: RADIOGRAPHS – *please ensure all relevant and recent radiographs are enclosed for patient assessment.*** |
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|  |  |  |
| --- | --- | --- |
| Radiographs enclosed  | Yes [ ]  | No [ ]  |
| DPT  | Date taken:\_\_/\_\_/\_\_\_\_ |
| Intra Oral | Date taken:\_\_/\_\_/\_\_\_\_ |

 | None taken [ ] *Please give reason for not providing radiographs*: |
| **SECTION 13: 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 14: 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 15: 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:…..........................................** |