## Form 1C: Assessing dentist referral to specialist pathway provider

### Patient details [or patient sticker]

|  |  |  |  |
| --- | --- | --- | --- |
| Patient name |  | Date of birth |  |
| Home address |  | Hospital ID number |  |
| Patient contact telephone number |  |

|  |  |
| --- | --- |
| Social history |  |
| Dental history |  |
| Extraoral assessment |  |
| Intraoral assessment |  |
| Treatment needs  |  |
| Treatment options discussed with the patient |  |

|  |  |
| --- | --- |
| Assessing dentist’s name |  |
| Dentist address  |  |
| Dentist telephone number |  |

|  |  |
| --- | --- |
| Indicate specialist dental skills/ resources required: |  |
| Indication for referral to specialist services |  |

**Dear colleague,**

The patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, whose details are enclosed, has had a full oral and dental health assessment and treatment plan prior to their commencement of cancer therapy on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

The oncology team has deemed this patient high risk for oral and dental health problems; please see their original referral letter enclosed.

Undertaking cancer therapy places this patient in the dental recall risk category requiring oral and dental health review and advice every 6 months.

Further to our conversation I would be most grateful if you could view the patient with the intention of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ {indicate treatment required}. Please complete the treatment prior to their cancer therapy start date to prevent delaying the patient’s cancer therapy as per Oral Health Provision for Cancer Pathways.

Please confirm with me and the patient’s oncology team when the patient’s treatment has been completed.

Thank you in advance for your help in preparing this patient for their cancer treatment.

Kind regards,

[Professional signature]