**Referral**

**Community Dental Service (CDS) - North Yorkshire and York**

**Please send completed referrals to:** [**referrals.hdftcommunitydentalservices@nhs.net**](mailto:referrals.hdftcommunitydentalservices@nhs.net)

Please fill in all mandatory boxes (marked with an asterisk) and provide as much information as possible. Incomplete referrals will not be processed and will be returned to the referrer.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| \*Patient Details (NHS number not mandatory) | | | | | | | | | | | | | | | | | |
| Title | Choose an item. | | | | | | | Surname | | | | Click or tap here to enter text. | | | | | |
| Forename(s) | Click or tap here to enter text. | | | | | | | Date of Birth | | | | Click or tap to enter a date. | | | | | |
| Gender | Choose an item. | | | | | | | NHS Number | | | | Click or tap here to enter text. | | | | | |
| Preferred Pronouns |  | | | | | | | Email | | | | Click or tap here to enter text. | | | | | |
| Telephone (Main) | Click or tap here to enter text. | | | | | | | Telephone (Mobile) | | | | Click or tap here to enter text. | | | | | |
| Address | Click or tap here to enter text. | | | | | | | | | | | | | | | | |
| Postcode | Click or tap here to enter text. | | | | | | |  | | | |  | | | | | |
| \*Parent/Guardian/Carer’s/Next of Kin Details | | | | | | | | | | | | | | | | | |
| Forename(s) | Click or tap here to enter text. | | | | | | | Surname | | | | Click or tap here to enter text. | | | | | |
| Address | Click or tap here to enter text. | | | | | | | | | | | | | | | | |
| Postcode | Click or tap here to enter text. | | | | | | | Telephone | | | | Click or tap here to enter text. | | | | | |
| \*Referrer Details | | | | | | | | | | | | | | | | | |
| Name | Click or tap here to enter text. | | | | | | | Job Title | | | | Choose an item. | | | | | |
| Address | Click or tap here to enter text. | | | | | | | | | | | | | | | | |
| Postcode | Click or tap here to enter text. | | | | | | | Email | | | | Click or tap here to enter text. | | | | | |
| Telephone | Click or tap here to enter text. | | | | | | | | | | | | | | | | |
| \*Social Worker/Advocate Details (If applicable) | | | | | | | | | | | | | | | | | |
| Name | Click or tap here to enter text. | | | | | | | Email | | | | Click or tap here to enter text. | | | | | |
| Address | Click or tap here to enter text. | | | | | | | | | | | | | | | | |
| Telephone | Click or tap here to enter text. | | | | | | | Is a child protection plan in place? | | | | | | | Choose an item. | | |
| \*General Practitioner (GP) Details | | | | | | | | | | | | | | | | | |
| Name |  | | | | | | | Telephone | | | |  | | | | | |
| Address |  | | | | | | | | | | | | | | | | |
| \*Medical History (all sections) | | | | | | | | | | | | | | | | | |
| State all medical conditions | | | | | Click or tap here to enter text. | | | | | | | | | | | | |
| List all medication being taken | | | | | Click or tap here to enter text. | | | | | | | | | | | | |
| Allergies | | | | | Click or tap here to enter text. | | | | | | | | | | | | |
| Medical teams/Hospitals currently involved in patient’s care | | | | | Click or tap here to enter text. | | | | | | | | | | | | |
| \*Dental Needs | | | | | | | | | | | | | | | | | |
| What dental treatment does the patient need (if known) | | | | | | | Click or tap here to enter text. | | | | | | | | | | |
| Reason you believe patient cannot be treated by GDP | | | | | | | | Click or tap here to enter text. | | | | | | | | | |
| Dental History (inc pain history if appropriate) | | | | | | | | | | | | | | | | | |
| Acute dental issues | Click or tap here to enter text. | | | | | | | | | | | | | | | | |
| Previous Treatment (tick all appropriate) | | | | | | | | | | | | | | | | | |
| Prevention/Acclimatisation | | | | | | | |  | Fillings without LA | | | | | | | |  |
| Fillings with LA | | | | | | | |  | Extraction with LA | | | | | | | |  |
| Treatment with IS/IV sedation | | | | | | | |  | Previous referral to CDS | | | | | | | |  |
| Scaling/ Periodontal care | | | | | | | |  | Treatment under GA | | | | | | | |  |
| What difficulties were encountered & what prevention plan is in place | | | | | | | | Click or tap here to enter text. | | | | | | | | | |
| \*Additional Needs (Please tick one of the following) | | | | | | | | | | | | | | | | | |
| Moderate/severe learning disabilities | | | | | |  | | Moderate/severe physical and/or communication impairment | | | | | | | |  | |
| Moderate/severe chronic mental health condition | | | | | |  | | Complex medical conditions | | | | | | | |  | |
| Severe dental anxiety or dental phobia | | | | | |  | | Children with clefts or dental abnormalities | | | | | | | |  | |
| Looked after children (LAC) with additional needs | | | | | |  | | Children with dental trauma | | | | | | | |  | |
| Children with complex dental conditions | | | | | |  | | Other  (reason) | | | Click or tap here to enter text. | | | | | | |
| Bariatric Patients | |  | | Height | Click or tap here to enter text. | | | Weight | | Click or tap here to enter text. | | | BMI | | Click or tap here to enter text. | | |
| Accessibility Needs | | | | | | | | | | | | | | | | | |
| Ability to communicate | | | | | Choose an item. | | Able to leave home | | | | | | | Choose an item. | | | |
| Able to transfer to dental chair | | | | | Choose an item. | | Able to consent | | | | | | | Choose an item. | | | |
| Additional Requirements | | | | | | | | | | | | | | | | | |
| Additional requirements to support delivery of care, eg hoist, communication/accessible information | | | | | Click or tap here to enter text. | | | | | | | | | | | | |
| Is an interpreter required | | | | | Choose an item. | | | Language | | | | Click or tap here to enter text. | | | | | |
| Radiographs | | | | | | | | | | | | | | | | | |
| Are radiographs included | | | | | Choose an item. | | | Type | | | | Click or tap here to enter text. | | | | | |
| Date Taken | | | | |  | | | Sent | | | | Choose an item. | | | | | |
| Referrer Declaration | | | | | | | | | | | | | | | | | |
| I have explained to the patient and/or parent/carer that I am referring them to the CDS for the reasons detailed above and they have agreed to the referral\* | | | | | | | | | | | | | | |  | | |
| I confirm that I have advised the patient that the CDS only provides care to patients who fit certain criteria and their referral will be assessed against these criteria. If these are not met the patient will not be accepted for care with the CDS\* | | | | | | | | | | | | | | |  | | |
| I confirm that I have advised the patient that the CDS does not offer emergency dental appointments to patients prior to assessment not to patients not retained under the service’s continuing care criteria. Emergency care provision is the responsibility of the referring dentist or via NHS 111\* | | | | | | | | | | | | | | |  | | |
| Dentist Referrals Only | | | | | | | | | | | | | | |  | | |
| I have discussed alternative methods of treatment (LA/RA/GA) and pain control | | | | | | | | | | | | | | |  | | |
| I have explained that the treatment provided on referral is a separate course of care and may incur further NHS changes where appropriate | | | | | | | | | | | | | | |  | | |
| I understand that this referral may only be accepted for a single course of treatment and then returned to your team for continuing care or share care where appropriate | | | | | | | | | | | | | | |  | | |
| Information Governance | | | | | | | | | | | | | | | | | |
| Does the patient agree to CDS accessing their medical information for the provision of their dental care? | | | | | | | | | | | | | | | Choose an item. | | |
| Does the patient agree to receive text message reminders for clinical appointments with the CDS? | | | | | | | | | | | | | | | Choose an item. | | |
| Return of Completed Referral Forms | | | | | | | | | | | | | | | | | |
| Signed | | | Click or tap here to enter text. | | | | | | | | | | | | | | |
| Date | | | Click or tap to enter a date. | | | | | | | | | | | | | | |