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| **PAEDIATRIC DENTISTRY REFERRAL FORM (CHILDREN 15 YEARS OLD AND YOUNGER)** | | | | | |
| **Surname:** | **First Name(s):** | | | | **Gender:**   Male   Female   Prefer not to say |
| **Date of Birth:** | **NHS Number:**  (If known) | | | | **Is this referral urgent?**   Yes   No |
| **Home Address:** | | **GP Name :** | |  | |
| **GP Address:** | |  | |
| **Post Code: Borough:** | |  | |  | |
| **Phone:** | | **Post Code:** | | **Borough:** | |
| **Mobile contact:** | | **Phone:** | |  | |
| **Interpreter Required?**  Yes   No | | **Which language?**  **BSL**  | | ……………………………………………. | |
| **Medical History, Disability**  Is patient under hospital care for a medical reason?  **Y / N**  If yes, which hospital: | | | **Medication** | | |
| **How does the above patient meet the Paediatric Dentistry Referral criteria?**   Dental Caries : likely GA  Complex medical or  Periodontal problems (provide details below) behavioural problems (*expand*  Soft Tissue Conditions   Dental caries – other : *below)*  (expand below why referral  Tooth surface loss – e.g.   should be accepted)  erosion  This is Level 1 and appropriate Dental trauma - Primary and Dental Anomalies – altered for training purposes  permanent. (expand under tooth structure, number, history) shape, size, form   Opinion about poor quality  Disorders of tooth eruption  NB are there Safeguarding first permanent molars (not and loss concerns or is child in the care RCT)  Surgical management e.g. un- of social services e.g. Looked  NB Consider obtaining ortho erupted teeth after children. Please provide  opinion first more details below. | | | | | |

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| **Why are you referring this patient? Include a charting of treatment needed with an indication of urgency and/or severity such as recent pain or antibiotic use**  *NB A failure to provide sufficient and legible information here may lead to rejection of this referral*  *Give an indication of urgency :*  *Chart treatment needed :* | | | | |
| **Dental treatment you have provided, tick relevant boxes (***expand above or below***) :**   Prevention including Fluoride Varnish  Restorations temp  permanent    Radiographs (*attach if available*)  Other e.g. Hall crowns   Attempted local anaesthesia  Unable to treat further (*expand above* )  ……………………………………………………………………. ……………………………………………………………………. | | | | |
| **Name of Referrer** | | **Date of referral** | | |
| **Job Title:** | **Organisation:** | | | **Date Received** (office use) |
| **Address:**  **Post Code:** | | | **Phone / Mobile: Secure Email:** | |

THIS REFERRAL WILL NOT BE ACCEPTED WITHOUT COMPLETION OF ALL SECTIONS ON COMPLETION