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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 purposespermanent. (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. LookedNB Consider obtaining ortho erupted teeth after children. Please provideopinion 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