NHS England

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: **Post Code:** **Borough:** **Phone:** **Mobile contact:**	**GP Name :** **GP Address:** **Post Code:** **Borough:** **Phone:**
Interpreter Required? ☐ Yes ☐ No	**Which language?** ..... **BSL** ☐

Medical History, Disability	**Medication**
Is patient under hospital care for a medical reason? **Y / N** If yes, which hospital:	

How does the above patient meet the Paediatric Dentistry Referral criteria?

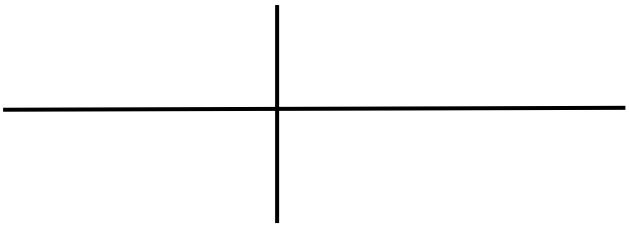
- ☐ Dental Caries : likely GA (provide details below)
- ☐ Dental caries – other : (expand below why referral should be accepted)
- ☐ Dental trauma - Primary and permanent. (expand under history)
- ☐ Opinion about poor quality first permanent molars (not RCT)
  NB Consider obtaining ortho opinion first
- ☐ Complex medical or behavioural problems (*expand below)*
- ☐ Tooth surface loss – e.g. erosion
- ☐ Dental Anomalies – altered tooth structure, number, shape, size, form
- ☐ Disorders of tooth eruption and loss
- ☐ Surgical management e.g. un-erupted teeth
- ☐ Periodontal problems
- ☐ Soft Tissue Conditions
- ☐ This is Level 1 and appropriate for training purposes
- ☐ NB are there Safeguarding concerns or is child in the care of social services e.g. Looked after children. Please provide more details below.

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
- ❑ Radiographs (*attach if available*)
- ❑ Attempted local anaesthesia
- ❑ Restorations temp ☐ permanent ☐
- ❑ Other e.g. Hall crowns
- ❑ Unable to treat further (*expand above*)

…… ……

Name of Referrer	**Date of referral**

Job Title:	**Organisation:**	**Date Received** (office use)

Address:	**Phone / Mobile:**
Post Code:	**Secure Email:**

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