Hertfordshire Community NHS
NHS Trust

SPECIAL CARE DENTAL SERVICE

Patient Referral Form – for use by General Dental Practitioners

All sections of this form must be fully completed to avoid unnecessary delays. Once completed please send this form to :

Clinical Director (Gill Lowey), Special Care Dental Service
The Red House, Harpenden Memorial Hospital, Carlton Road, Harpenden, AL5 4TA
Tel: 01582 714195/714190 Fax :01582 713657

Only patients who meet the service acceptance criteria will be considered

SECTION 1- Acceptance Criteria

The patient being referred is a Hertfordshire resident who :

♦ Is a wheelchair user unable to transfer to the dental chair without the use of a hoist	
♦ Has a diagnosed moderate/severe learning disability with co-operation difficulties who cannot be managed in General Dental Practice	
♦ Has a diagnosed moderate/severe mental health problem with co-operation difficulties who cannot be managed in General Dental Practice	
♦ Is a child of 8 years or under (at time of referral) requiring dental treatment under sedation due to unmanageable behavioural problems	
♦ Has a complex medical condition not manageable in General Dental Practice	

Please explain in detail why you are referring this patient

SECTION 2 – Patient details

Title		Surname	
Date of Birth		First Name	
Address			
Postcode		NHS No.	
Home Tel No.		Daytime Tel No.	
		Mobile Tel No.	

SECTION 3 – Treatment Requested (Please use block capitals)

Has treatment been attempted ?	***Yes***		***No***	
Does this patient need an interpreter ?	***Yes***		***No***	

SECTION 4 – Details (Please use block capitals)

Have x rays been taken ?	***Yes***		***No***	
If yes are they attached to this referral ?	***Yes***		***No***	
Is this patient in unmanageable pain ?	***Yes***		***No***	
Has the patient ever displayed any aggressive behaviour ?	***Yes***		***No***	
If yes, please give details				

Referring Dentist Name (Please print)		Referring Dentist Clinic stamp
Practice Telephone No		
Date		
Dentist Signature _____		

PATIENT/PARENT/LEGAL GUARDIAN *Please delete as appropriate:*

1. I would be happy to accept an appointment at the clinic with the shortest waiting time
2. I would prefer to wait for an appointment at the clinic closest to my home

I confirm that I understand and agree with the reasons for this referral as discussed with my dentist.

Signature _____ Date

Relationship to patient

SECTION 5 – TRIAGE OUTCOME Date

Patient accepted for treatment	
Patient does not meet any of the criteria for this service	
Treatment requested not available from this service	
More appropriate for Clinical Assessment Service(CAS)/Hospital referral	
Incomplete referral form	
Comments	

If you have any concerns regarding this outcome please contact PCT Dental Commissioners