Glasgow Dental Hospital Referral Form

Date of Referral:___/___/___

Section A - Patient Details:

Surname:_____Male/Female

First Names:_____Date of Birth___/___/__

Address:_____

Town:_____Post Code:_____

Phone: (Day)_____Eve: _____Mobile:_____

- Referring Dentist/Doctor Details:

Name:
Address:

Phone:

Hospital Use Only:

Is patient registered with practice ☐ CHI No. (if known) ☐☐☐☐☐☐☐☐☐☐

Routine: ☐ Urgent: ☐ * You must justify urgent request overleaf Rapid Access ☐

Has patient attended GDH before? Yes ☐ No ☐ If so state Hosp No ☐

Referral to:

(please refer to individual guidance notes when completing this section)

Section B - Paediatric Dentistry (not GA Assessment) **(please read guidance notes 1)**

Problem: Is the patient symptomatic ☐ Radiographs enclosed ☐

Dento-alveolar trauma1 ☐ Molar/incisor hypoplasia/mineralisation ☐

Tooth discoloration ☐ Developmental defects ☐

Non-carious tooth surface loss ☐ Soft tissue disorders/lesions ☐

Medically compromised ☐ High caries rate *or* pain from decayed teeth* ☐

Learning difficulties and special needs* ☐ Anxiety and behaviour management* ☐

Other ---------- ☐

*** Should be referred to Community Dental Service in the first instance**

Section C - Restorative:

Radiographs enclosed ☐

Standing teeth:

8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8

CPITN:

Section C1 - Conservation:

(please read guidance notes 2a)

Problem:

For advice only ☐	For Specialist treatment (at Consultant's discretion) ☐	Undergraduate treatment ☐
Toothwear ☐	Fixed Prosthodontics ☐	Pain Diagnosis ☐
Purely Cosmetic (advice only) ☐	Maxillofacial/Cleft ☐	Anxiety/Hypnosis ☐
Other(specify)---------- ☐	Caries present ☐	Is the caries controlled ☐

Section C2 - Endodontics:

(please read guidance notes 2b)

Problem:

De novo ☐	Re-treatment ☐
Periradicular surgery ☐	Trauma* ☐
Are adjacent pockets <4mm ☐	Is tooth caries free and restorable ☐
Duration of condition ☐	Previous episode (provide details in Section G) ☐

***Patients under 16 years of age should be referred to Paediatric Dentistry**

Section C3 - Prosthodontics:

(please read guidance notes 2c)

Problem:

For advice only: ☐	For treatment: Specialist (at Consultant's discretion) ☐	Undergraduate ☐
	Edentulous ☐	Partially dentate ☐
Are dentures worn by the patient:	Yes ☐	No ☐
Were the dentures made by you:	Yes ☐	No ☐
Periodontal Status	Disease present - (give details in Section F) ☐	Is the caries controlled ☐

Section C4 - Periodontology: **(please read guidance notes 2d)**

Problem:

For advice only ☐ or For specialist treatment ☐
(at Consultant's discretion)

Please refer to guidance notes for an outline of those conditions for which specialist treatment is available. Patients with poor oral hygiene or obvious calculus deposits will not be accepted for treatment.

Section D - Orthodontics: **(please read guidance notes 3)**

Problem:

For Advice only ☐ or For specialist treatment ☐
(at Consultant's discretion)

Section E - Oral Surgery/Oral Medicine: **(please read guidance notes 4)**

Problem:

Oral Surgery ☐ Oral Medicine ☐

Section F – Radiology: **(please read guidance notes 5)**

Problem:

Previous relevant radiographs included ☐ When were they taken? ☐

Section G - Referral Details:

Reason for referral: (Justify urgent requests)

History of complaint and duration of condition:

Previous investigation and treatment:

Relevant medical and drug history:

Examination findings:

Provisional diagnosis:

Section H – Paediatric Assessment:

Section H1 - Provisional Treatment Plan: **(please read guidance notes 6)**

Extraction of: _____|_____
|

Justification for Referral:

- I have discussed alternative means of care as specified in the advice sheet (Appendix I)
- I have explained to the parent /guardian/patient (*delete as appropriate) the proposed procedure and the risks of general anaesthesia as specified in the advice sheet (Appendix II)
- I have explained that the treatment plan may be changed at the assessment appointment and I have explained that the parent/guardian/patient will be advised of any such changes.

(NB sign end of referral sheet)

Section H2 – Parent/Guardian/Patient to complete

I confirm that Dr/Mr/Mrs/Miss/Ms_____ has discussed with me the alternative means of care as specified in advice sheet (Appendix I).

I am satisfied with the explanation given to me for the need for referral. I agree to the referral for assessment for sedation/general anaesthesia following the explanation of the proposed procedure and the risks of general anaesthesia as specified in the advice sheet (Appendix II).

Signed:_____Date: _____
parent/guardian/patient (delete as appropriare)

Section I – Signed:_____Date:_____

Referring Practitioner

For Hospital Use Only:

Accept ☐ Priority: Urgent ☐ Soon ☐ Routine ☐

Reject ☐ Because of insufficient information ☐ Inappropriate referral ☐

Advice only ☐ Date vetted: ☐ Vetted by:_____Signed

CHI No

Internal Audit
