Bridgewater Community Healthcare NHS
NHS Trust
Tameside and Glossop Community Dental Service

GA - REFERRAL FORM

DENTAL SERVICE

Crickets Lane Clinic, Ashton –under-Lyne OL6 6NG Tel: O161- 342-7857

PATIENT DETAILS

First Names _____ Surname _____

Date of Birth _____ Age _____

Address _____ Home Tel. No. _____

_____ Contact Tel. No. _____

Post Code _____

Patient Dental History: Are they a regular attender? YES/NO
(This box must be completed)

Give details, i.e. what treatment, if any, have these children experienced? How do they react in a dental surgery?

_____

_____

Justification for referral and alternative methods discussed or attempted.

(a) Local anaesthesia with or without sedation has been offered but has proved inadequate or been refused ***YES/NO**
(b) Local anaesthesia is contraindicated, e.g. the presence of sepsis despite drainage ***YES/NO**
(c) Multiple sites of pain ***YES/NO**
(d) Other reason (please specify) *** Please delete as appropriate**

_____

_____

PROPOSED TREATMENT PLAN
Number of extractions requested:

Deciduous teeth ☐ Permanent teeth ☐

Please chart teeth requiring extraction
(use upper case for primary dentition):

R L

REFERRING DENTIST
May I refer my patient to your clinic for the above treatment under general anaesthesia. I have been unable to treat the patient by conventional means. I have given a thorough and clear explanation of the risks involved and the alternative methods of treatment available.

PRACTICE STAMP

Medical History Form attached

Yes ☐
Dentist's Signature _____
Date of referral _____

Tel. No. _____ **Print Dentist's Name** _____

RETAIN COPY IN PRACTICE RECORDS

GA – MEDICAL HISTORY

COMMUNITY DENTAL SERVICE

Confidential Medical History

To be completed by referring Dentist

Patient's Name _____ D.o.B. _____

Name of Doctor _____

Address of Doctor _____

Please tick box

1. General Anaesthesia

Have you ever had a general anaesthetic Yes ❑ No ❑

If Yes, we need to know how long ago it was

More than one year? ❑ or how many months ago? Months

Have you or any member of your family ever had a reaction to any sort of anaesthetic drug or is there a family history of malignant hyperthermia?

Yes ❑ No ❑

2. Medical Conditions

Does this patient have a history of:

- Heart problems, murmurs or heart operations Yes ❑ No ❑
- Rheumatic fever Yes ❑ No ❑
- High blood pressure Yes ❑ No ❑
- Diabetes Yes ❑ No ❑
- Asthma or chest problems Yes ❑ No ❑
- Do you use an inhaler? Yes ❑ No ❑
- Yellow Jaundice, Hepatitis or Liver problems Yes ❑ No ❑
- Fits or Blackouts or Epilepsy Yes ❑ No ❑
- Sickle Cell or Thalassemia or family history of these Yes ❑ No ❑
- Bleeding disorders or family history of these Yes ❑ No ❑

- Have you had steroids in the last 6 months Yes ❑ No ❑
- Any other serious illness Yes ❑ No ❑

  If Yes, what? _____
- Have you visited your doctor in last two years Yes ❑ No ❑
- If Yes, what for? _____

3. Current Health

- Do you have a cold, flu or other illness? Yes ❑ No ❑
- Do you carry a warning card or bracelet? Yes ❑ No ❑
- Are you, or might you be pregnant? Yes ❑ No ❑
- Are you taking any medicine or tablets or drugs? Yes ❑ No ❑

  If Yes, please list ……

  ……

4. Allergies

- Are you allergic to anything (e.g. eggs, penicillin, sticking plaster)? Yes ❑ No ❑

  If Yes, please list ……

  ……

5. Is there anything else you can think of we may need to know about? Yes ❑ No ❑

If Yes, please list ……

……

I confirm the above information is correct **…….**
(Parent/Legal Guardian's signature)

I have confirmed the above information with the parent/legal guardian **…….**
(Dentist's signature)

Date: …….

GENERAL GUIDANCE & REFERRAL CRITERIA FOR EXTRACTIONS FOR CHILDREN UNDER GENERAL ANAESTHESIA

"This service is reserved for children with pain who cannot accept treatment using alternative methods such as local anaesthesia with or without sedation."

Referrals will be accepted for children requiring treatment:

- For whom local anaesthesia with or without sedation has been offered but has proved inadequate or been refused.
- For whom local anaesthesia is contraindicated, e.g. the presences of sepsis despite drainage.
- For multiple extractions in young or very nervous children who are experiencing pain from a number of sites.

The following further criteria must also be met:

1. Age - minimum of 3years to a maximum of 12 years.
2. Weight - minimum 15Kg to a maximum of 50Kg.
3. Simple exodontia only - no surgical extractions.
4. Relevant radiographs must be included for any permanent extractions.

We **do not** accept orthodontic extractions as we wish to reserve this service for children in pain.

- If over 3years but less than 15Kg
  - CANNOT ACCEPT
- If under 12 years but more than 50Kg
  - CANNOT ACCEPT