**REFERRAL TO THE HULL AND EAST RIDING ADULT SPECIAL CARE DENTISTRY SERVICE**

\* Mandatory Fields

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| PATIENT DETAILS |
| Title |  | Referral Date\* |  |
| Forenames\* |  | Surname\* |  |
| Gender (🗸) | M |  | F |  | Date of Birth \*  |  |
| Telephone Number \* |  |
| Consent for Text Reminders  | Yes  | No  | NHS Number  |  |
| Address\* |  |
| Postcode\* |  | Ethnicity |  |
| MAIN CARER DETAILS |  |
| Full Name |  |
| Address |  |
| Telephone Number:  |  |
| Email Address: |  |
| Is an interpreter required?\* | Yes | No | If yes, please state preferred language or requirements |  |
| Please confirm if interpreter was present on completion of this form (🗸) | Yes  | No |
| Details of care professionals involved in patient care (e.g. social worker, community learning disability nurse)  |

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| REFERRER DETAILS |
| Patient does not have a dentist\* (🗸) |  | I am the referring dentist \* (🗸) |  |
| Name\*  |  |
| Job Title\* |  |
| Address\* |  |
| Telephone Number\* |  |
| Email Address\* (nhs.net if available) |  |

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| PATIENT GENERAL MEDICAL PRACTITIONER (GMP) DETAILS |
| Name |  |
| Practice Address\* |  |
| Postcode\* |  |
| Telephone Number\* |  |

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| REFERRER DECLARATION\* (🗸) |
| ☐ I have explained to the patient and/or parent/carer that I am referring them to Hull and East Riding Adult Special Care  Dental Service for the reason/treatment detailed overleaf ☐ The patient and/or parent/carer has agreed to the referral and completed a medical history form ☐ I will continue to see the patient for routine reviews and prevention ☐ The patient and/or parent/carer are aware this is a primary care referral and therefore standard NHS Dental Charges apply if  not exempt.  |
| REFERRER SIGNATURE\* | DATE\* |
|  |  |
| Please send the completed referral form and relevant radiographic images to:**Community Dental Service, Highlands Health Centre, Lothian Way, Bransholme, Hull, HU7 5DD****or email to** **chcp.dentalreferrals@nhs.net** |
| REASON FOR REFERRAL: \* relevant supplementary page to be completed  |
|  | Tick | Comments |
| Complex Medical History  |  |  |
| Complex Physical Disability  |  |  |
| Learning Disability / Autism / ADHD |  |  |
| Dementia / Vulnerable Older Adult |  |  |
| Dental Phobic\* |  | **Please complete supplementary dental anxiety/phobia form**  |
| Domiciliary\* |  | **Please complete supplementary domiciliary form**  |

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| Please explain why the patient requires referral to the Adult Special Care Dental Service \* |
| What dental treatment/prevention have you already provided for this patient \* |
| What treatment does the patient require from the Adult Special Care Dental Service \* |

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| Does the patient have a routine or urgent dental need? |
| Routine  | Urgent Acute Pain Antibiotics  Swelling If ticked how many courses …………….. Bleeding Please note this is not an emergency dental service  |

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| Radiographs Taken:  |
| 🞏 Bite wings 🞏 Pan Oral 🞏 Periapical 🞏 OtherIf not taken please give reason why not |
| Practitioners are reminded that where appropriate, diagnostic quality radiographs should be taken before referral. Please provide the original or a good quality copy (digital radiographs should be printed on photographic paper) of a radiograph with the referral to avoid unnecessary additional radiographic exposure to the patient as per FGDP Guidance. Failure to do so may be seen as a breach of regulations. Where no radiograph is supplied, a full explanation of the reason for omission must be submitted. Every effort will be made to return original radiographs with correspondence. We are happy to accept digital radiographs by email with patients name and date of birth in subject box.  |

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| ADDITIONAL INFORMATION |
|  | Tick | Comments |
| Are there issues with communication? | Yes |  |  |
| No |  |
| Is the patient able to leave home? | Yes |  |  |
| No |  |
| Is the patient a wheelchair user? | Yes |  |  |
| No |  |
| Is the patient able to transfer into the dental chair? | Yes |  |  |
| No |  |
| Has the patient got reduced capacity to make decisions? | Yes |  |  |
| No |  |

**MEDICAL HISTORY QUESTIONNAIRE**

Name of patient…………………………………………………………. Date of Birth……………………………….

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| **Medical Questionnaire**  | **YES**  | **NO** |
| Are you allergic to anything, for example, latex, foods, pollen, house dust, animals, local or general anaesthetic?  |  |  |
| Do you carry a medical warning card? |  |  |
| Are you under the care of any specialist or consultant? |  |  |
| Have you had any major hospital admissions in the past 12 months? |  |  |
| Have you ever been treated for any form of cancer, had radiotherapy or chemotherapy? |  |  |
| Do you take a tablet once weekly or any medications for your bones? |  |  |
| Have you taken any steroid medication in the last 6 months? |  |  |
| Do you have any problems with your heart? E.g. oedema, palpitations or angina? |  |  |
| Do you have a pacemaker, nerve stimulator, heart valve replacement or ever had rheumatic fever or endocarditis? |  |  |
| Have you ever been tested for sickle cell disease, or have any form of anaemia? |  |  |
| Do you have high or low blood pressure? |  |  |
| Have you ever had a stroke (CVA) or trans-ischaemic attack (TIA)? |  |  |
| Do you have a bleeding disorder or bleed for a long time if injured? |  |  |
| Do you have any problems with your breathing, such as asthma, bronchitis or emphysema? |  |  |
| Do you require oxygen supplementation? |  |  |
| Do you have any problems with your liver or ever had jaundice or hepatitis? |  |  |
| Do you have any problems with your kidneys? |  |  |
| Do you have diabetes? |  |  |
| Do you have any thyroid problems? |  |  |
| Do you have epilepsy or suffer with any other condition resulting in fits or faints? |  |  |
| Have you ever had an organ transplant, shunt or joint replacement? |  |  |
| Do you have a degenerative disorder such as MS, Motor Neurone Disease, Huntington’s or Parkinson’s disease? |  |  |
| Do you have a problem with swallowing or are peg fed? |  |  |
| Do you have arthritis? |  |  |
| Do you have any mental health problems such as depression, bi-polar disorder, anxiety states, schizophrenia, eating disorder or any other mental health problem?Please give details/specify ………………………….. |  |  |
| Do you have a learning difficulty, autistic spectrum disorder, ADHD or other syndrome?Please give details/specify …………………………… |  |  |
| Do you have dementia? If yes is this mild/moderate/severe? ....................................... |  |  |
| Do you have impaired hearing or sight? |  |  |
| Do you have any problems reading or writing? |  |  |
| Do you have any mobility problems?If yes what aids if any do you require? ............................................. |  |  |
| Do you weigh over 21 stone? |  |  |
| How much alcohol (if any) do you drink per week? (NB: A pint of lager = 2 to 3 units). No of units: |  |
| Have you ever in the past 10 years smoked cigarettes, cigars or a pipe, or do you vape? |  |  |
| Have you ever used chewing tobacco? |  |  |
| Do you use any recreational drugs or legal highs? |  |  |
| Do you have a DNAR/ ReSPECT in place? |  |  |
| If this patient lacks capacity; |  |  |
| Is there a Lasting Power or Attorney (LPA) or Court Appointed Deputy for health and welfare? |  |  |
| If yes who are they? ...................................................................................................................................... |
| **Females only**......is there a chance that you might be pregnant or are you breast feeding? |  |  |
| Is there anything else about your health I need to know about? |
| **Medication List** (including any regular infusions or injections, self-prescribed or herbal medication) – Please bring a copy of an up to date repeat prescription or MARS chart if available. |