**Eligibility Criteria for Domiciliary Care Supplementary Form**

(must be accompanied by the Adult Special Care Referral Form)

Please complete all sections to avoid delaying referral process

**Patient Name**:…………………………………………. **Date of Birth**: …………………………….

**Contact Telephone Number**: ………………………………………………………………………

**Appointments:**

How does the patient access their GP? Attend Surgery

 Home Visit

If the patient has a hospital appointment, how does he/she attend?

 Ambulance

 Taxi

 Car

 Other ……………………………………..

Does the patient have someone to bring them to the surgery? Yes No

**Mobility Aid**

Able to walk unaided.

Able to walk aided.

Walking Stick

Walking Frame

Wheelchair User

Bedbound

If wheelchair user are, they transferable to the dental chair? Yes No

If yes would a hoist be required Yes No

Is a bariatric chair required Yes No

**History:**

Is there any history of violence or aggression from the patient which we should be aware of Yes No

Are there any safeguarding issues regarding the patient? Yes No

Are there any issues with capacity? Yes No

Are there any special access requirements for the patient?

………………………………………………………………………………………………………

………………………………………………………………………………………………………

Does the patient hold an exemption certificate? Yes No

If referring for treatment relating to dentures please state whether or not the patient has any natural teeth Yes No