**GENERAL ANAESTHETIC DENTAL ASSESSMENT SERVICE**

**(2 – 18 YEARS ONLY)**

\* Mandatory Fields

|  |  |  |  |  |  |  |  |  |  |  |  |
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| **PATIENT DETAILS** | | | | | | | | | | | |
| **Title** |  | | | | | | | **Referral Date \*** | |  | |
| **Forenames\*** |  | | | | | | | **Surname\*** | |  | |
| **Gender \*** | **M** |  | | **F** | | |  | **NHS Number** | |  | |
| **Telephone Number\*** |  | | | | | | | **DOB\*** | |  | |
| **Address\*** |  | | | | | | | | | | |
| **Postcode\*** |  | | | | | | | **Ethnicity** | |  | |
| **Address of School/Nursery** |  | | | | | | | | | | |
| **Social Worker/Family Support Worker (if applicable)** |  | | | | | | | | | | |
| **MAIN CARER DETAILS** | | | | | | | | | | | |
| **Full Name \*** |  | | | | | | | | | | |
| **Telephone Number \*** |  | | | | | | | | | | |
| **Email Address \*** |  | | | | | | | | | | |
| **Is an interpreter required?\*** | **Yes** | | **No** | | **If yes, please indicate preferred language or requirements** | | | |  | | |
| **Please confirm if Interpreter was present on completion of this form** | | | | | | | | | **Yes** | | **No** |
|  | | | | | | | | | | | |
| **REFERRER DETAILS** | | | | | | | | | | | |
| **Name\*** |  | | | | | | | | | | |
| **Practice Address\*** |  | | | | | | | | | | |
| **Postcode\*** |  | | | | | | | | | | |
| **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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| **DECLARATION \*** |
| **Duties of referring dentist**   1. I confirm that I have discussed treatment options with the patient/parent/legal guardian,   including the alternatives to general anaesthesia   1. I confirm that the risks associated with general anaesthesia have been discussed with the   patient/parent/legal guardian   1. I will continue to see the patient for routine reviews and prevention   Signature of referring dentist……………………………………………… Date ……………................  **TO BE COMPLETED BY PARENT/LEGAL GUARDIAN**   1. I agree to the treatment proposed. It has been explained to me by the dentist named on this form 2. I have completed a medical history for this referral   Signature……………………………………………..Print Name………………………………………………..  Date…………………………………………………..Relationship to patient…………………………………… |

**General Anaesthetic Dental Assessment Service**

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

**To be completed by referring dentist:**

1. Is the patient experiencing pain YES / NO (Please circle)
2. Is there any swelling YES / NO (Please circle)

If yes is it Extraoral

Intraoral

1. Has patient been prescribed antibiotics for dental infection YES / NO
2. Relevant dental History…………………………………………………………….

…………………………………………………………………………………………

1. Has the patient had previous extractions under General Anaesthesia

YES / NO (Please circle)

If Yes Please Give Date……………………………………………………………..

1. Justification for General Anaesthesia………………………………………………

………………………………………………………………………………………….

Treatment

Teeth to be extracted : Complete chart below, signify roots to be extracted by X above the tooth and supplemental/supernumerary teeth by S

R L

If permanent teeth or sound primary molars are to be extracted, radiographs to check for the presence of unerupted teeth and root morphology are required.

**Please enclose relevant radiographs, if not the referral will be returned.**

**Have radiographs been taken?** YES / NO (Please circle)

**Radiographs enclosed:**

OPT YES / NO

Periapical YES / NO

Bitewings YES / NO

If not taken please give reason why not ………………………………………………

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| 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 |

**General Anaesthetic Dental Assessment Service**

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

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| **Medical Questionnaire** | **YES** | **NO** |
| Is your child up to date with all their vaccinations? |  |  |
| Are they allergic to anything? E.g. latex, foods, pollen, house dust, animals, local or general anaesthetic – please specify: |  |  |
| Do they have any problems with their heart? |  |  |
| Do they have a pacemaker, nerve stimulator, heart valve replacement or ever had rheumatic fever or endocarditis? |  |  |
| Do they have any problems with their breathing, such as asthma, bronchitis? |  |  |
| Do they require oxygen supplementation? |  |  |
| Do they have a problem with swallowing or are peg fed? |  |  |
| Have they ever had any form of anaemia or diagnosed with sickle cell disease? |  |  |
| Do they have a bleeding disorder or bleed for a long time if injured? |  |  |
| Have they ever had an organ transplant, shunt or joint replacement? |  |  |
| Do they have diabetes? |  |  |
| Do they have any problems with their liver or ever had jaundice or hepatitis? |  |  |
| Do they have any problems with their kidneys? |  |  |
| Do they have epilepsy or suffer with any other condition resulting in fits or faints? |  |  |
| Do they have a learning difficulty, global development delay, autistic spectrum disorder, ADHD or other syndrome? |  |  |
| Do they have impaired hearing or sight? |  |  |
| Do they have any problems communicating, reading or writing? |  |  |
| Do they use any communication aids? E.g. Makaton, PECS, Story boards, BSL |  |  |
| Do they have any mobility problems? E.g. hypermobility, wheelchair use |  |  |
| Do they carry a medical warning card? |  |  |
| Have they had any major hospital admissions or operations? |  |  |
| List ALL Healthcare Professionals involved in your child’s care: including name, role and hospital | | |
| Medication List: including pain relief, inhalers, contraception, self-prescribed and herbal medications | | |
| Is there anything else about your child’s health we need to know about? | | |

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| **Please send the completed referral form and relevant radiographic images to:**  **Community Dental Referral Service, Highlands Health Centre, Lothian Way, Bransholme, Hull, HU7 5DD** |