**REFERRAL TO THE HULL AND EAST RIDING**

**SPECIALIST PAEDIATRIC DENTAL SERVICE CHILD 0-16 YEARS**

\* Mandatory Fields

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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 \*** |  | | | | | | | | | | | |
| **Address \*** |  | | | | | | | | | | | |
| **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** | | | | | | | | | | | | |
| **Patient does not have a dentist\*** | | | | | |  | | **I am the referring dentist\*** | | | |  |
| **Name\*** |  | | | | | | | | | | | |
| **Job Title\*** |  | | | | | | | | | | | |
| **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\*** |  |

|  |  |
| --- | --- |
| **REFERRER DECLARATION \*** | |
| 🗌 I have explained to the patient and/or parent / carer that I am referring them to Hull and East Riding Specialist Paediatric Dental Service for the reason / treatment detailed overleaf.  🗌 The patient and/or parent / legal guardian has agreed to this referral and completed a medical history form.  🗌 I will continue to see the patient for routine reviews and prevention | |
| **REFERRER SIGNATURE\*** | **DATE\*** |
|  |  |
| Please send the completed referral form and relevant radiographic images to**:**  **Community Dental Referral Service, Highlands Health Centre, Lothian Way, Bransholme, Hull, HU7 5DD**  **or email to chcp.dentalreferrals@nhs.net** | |

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| --- | --- | --- |
| **REASON FOR REFERRAL \* (please see referral criteria)** | | |
|  | **(🗸)** | **Please give Details** |
| **Dental caries in primary teeth** |  |  |
| **Dental caries in permanent teeth** |  |  |
|  |  | **Pain (please circle) Yes / No**  **Swelling (please circle) Yes / No**  **Antibiotics (please circle) Yes / No**  **If Yes how many courses** |
| **If patient has multiple carious primary teeth, or abscesses then a referral to the GA Assessment Service should be made NOT a referral on this form** | | |
|  |  |  |
| **Other Dental / oral problem (please specify)** |  |  |
| **Children with poor co-operation / anxiety** |  |  |
| **Trauma** |  | **please also complete trauma form** |
| **Dental development conditions**  **(including hypodontia, Amelogenesis and Dentinogenesis Imperfecta, Molar Incisal Hypomineralisation)** |  |  |
| **Looked after children / safeguarding concerns** |  |  |
| **Learning disability / Autism / ADHD** |  |  |
| **Complex physical disability** |  |  |
| **Complex medical conditions** |  |  |

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| **DENTAL TREATMENT** |
| **What dental treatment does the patient need? \* (please state)** |
| **ABILITY TO CO-OPERATE** |
| **What treatment have you attempted to provide? \* (please state)** |
| **What difficulties were encountered? \* (please state)** |
| **What Prevention have you provided? \***  🞏 Diet Advice 🞏 Toothbrushing 🞏 Fluoride Toothpaste 🞏 Fluoride Varnish Application  Further Details: |

|  |
| --- |
| **RADIOGRAPHS TAKEN:**  🞏 Bite wings 🞏 Pan Oral 🞏 Periapical 🞏 Other  If 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 |

**MEDICAL HISTORY QUESTIONNAIRE**

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

|  |  |  |
| --- | --- | --- |
| **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 including self-prescribed and herbal medications | | |
| Is there anything else about your child’s health we need to know about? | | |