|  |  |  |  |
| --- | --- | --- | --- |
| **Patient Name** |  | Date of Birth  |  |
| **Address** |  |
| **Contact Telephone Number** |  |
| Name of Parent/Guardian  |  |
| Relevant Medical History |  |
| **Name, Address, Tel No and email address of Referring Clinician** |  |
| If referral from A&E please provide details of patients General Dental Practitioner  |  |
| Date and Time of Trauma |  |
| History of trauma/details of incident  |  |
| Diagnosis and status of apex |  |
| Treatment provided (with dates)  |  |
| Radiographs taken?If yes what type of radiograph **Please enclose with referral**  |  |
| **For avulsed teeth** |
| Extra-oral dry time |  |
| Storage medium |  |
| Total extra-oral time |  |

**PAEDIATRIC DENTAL TRAUMA**

Direct referral to Specialist Paediatric Dental Services

Highlands Health Centre, Lothian Way, North Bransholme, Hull, HU7 5DD Phone: 01482 303620

**PLEASE EMAIL TO : chcp.dentalreferrals@nhs.net**

Please complete all sections of the form