Berkshire Community Dental Service - Referral Form

This form is for Health and Social Care professionals and/or family wishing   
to self-refer a patient into the service.

This referral form is not the appropriate route for referral of patients who have acute dental problems that require urgent or emergency dental services. Please contact 111, emergency dental services, or your general dental practitioner if you have one, to seek emergency or urgent care.

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| **PATIENT DETAILS** | | | |
| Name: | Date of Birth: | Male/Female: | NHS number *(If known)* |
| Address *(including postcode)* | | | Ethnicity: |
| Telephone numbers:   Home: Work: Mobile: | | | |
| Email Address: | | | |
| Details of next of kin/responsible person:  ***A relative or carer with knowledge of the patient’s medical and dental problems should accompany any patient with communication or mobility problems.*** | | | |
| Patient Mobility Status:  □ Housebound □ Wheelchair user □ Needs hoist or assistance to transfer to chair | | | |
| Additional Information - communication/language difficulties, visual or hearing impairment, challenging behaviour: | | | |
| Patient Exemption Status: □ Exempt □ Not Exempt  ***Evidence of exemption must be provided at the first appointment.***  If exempt, please indicate reason: □ Under 18 years □ 18 years and in full time education  □ Pregnant □ Had a baby in last 12 months  □ Income support □ Income based jobseeker’s allowance  □ Income related employment & support allowance  □ Pension credit guarantee credit | | | |
| Disabilities (please tick all that apply):  □ Learning disability □ Physical disability □ Mental Health problem □ Dementia  □ Complex Medical problem □ Hearing impairment □ Visual impairment □ Language | | | |
| Preferred method of communication:  □ Letter □ Large Print Letter □ Telephone □ Email □ Text | | | |

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| **GP DETAILS** | |
| Name: | Telephone number: |
| Address *(including postcode)* | |
| Details of Consultant *(if required)* | |
| **Please attach a recent medical history form signed by the patient or complete the medical history form on Page 3** | |

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| **REFERRER’S DETAILS** | | |
| Name of Referrer: | Signature: | Date: |
| Relationship to Patient &/or Job Title: | | |
| Address *(including postcode)* | | |
| E-mail Address: | | Telephone Number: |
| I have provided the patient with a copy of the referral form: □ Yes □ No | | |
| Patient /Next of Kin Signature: | | Date: |

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| **DETAILS OF REFERRAL** |
| Reason for Referral – *see p4 for guidance on criteria:*  □ Child with additional needs such as learning, physical or severe medical disability  □ Person with learning, physical or severe medical disability impacting on dental treatment  □ Person with severe mental health problem or dementia impacting on dental treatment  □ Person with severe dental phobia whose needs can’t be met in NHS sedation services  □ Person unable to leave home and may require domiciliary treatment - *assessed on an individual basis* |
| **Please give a description of the dental problem? *e.g. pain/loose tooth/broken filling*** |

Please return the completed forms via post to: **Referrals, CDS HQ, Skimped Hill Health Centre, Skimped Hill Lane, Bracknell, RG12 1LH**Alternatively, this form can be emailed direct to[**cds.hq@berkshire.nhs.uk**](mailto:cds.hq@berkshire.nhs.uk)from a secure email address.

For any queries regarding the status of your referral, please ring our referral hub on **0118 904 1525**

Please note that this referral form will be returned to you if it is not fully completed

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| **Confidential Medical History Questionnaire**  **This medical history form must be completed.**  **If you answer yes to any questions, please give as much detail as possible.**   |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | **Name:** | | **Date of Birth:** | | | | | | | | | | **Mobile Phone *(for text reminders)*** | | **Home Phone Number:** | | | | | | | | | | **NHS Number:** | | **Doctor's Name and Surgery Address:** | | | | | | | | | | **Do you have a social or support worker?** If yes, please give name and contact details: | | | | | | | | | | | |  |  | |  |  |  |  |  |  |  | | 1. Have you ever had and heart disease/murmur or angina? | | | | | | | | | | | Yes | No | |  |  |  |  |  |  |  | |  | | | | | | | | | | | 2. Have you ever had heart surgery? | | | | | | | | | | | Yes | No | |  |  |  |  |  |  |  | |  |  | |  |  |  |  |  |  |  | | 3. Do you suffer from hypertension (High blood pressure)? | | | | | | | | | | | Yes | No | |  |  |  |  |  |  |  | |  |  | |  |  |  |  |  |  |  | | 4. Have you ever suffered from epilepsy/convulsions/fits/faints/blackouts? | | | | | | | | | | | Yes | No | |  |  |  |  |  |  |  | |  |  | |  |  |  |  |  |  |  | | 5. Have you ever suffered from any chest problems/ (Asthma/Bronchitis/TB) | | | | | | | | | | | Yes | No | |  |  |  |  |  |  |  | |  |  | |  |  |  |  |  |  |  | | 5. Do you or any close family members have diabetes? | | | | | | | | | | | Yes | No | |  |  |  |  |  |  |  | |  |  | |  |  |  |  |  |  |  | | 6. Do you suffer from any bleeding disorders or bruise easily? | | | | | | | | | | | Yes | No | |  |  |  |  |  |  |  | |  |  | |  |  |  |  |  |  |  | | 7. Have you ever suffered from any infectious diseases (including HIV/Hepatitis/Jaundice)? | | | | | | | | | | | Yes | No | |  |  |  |  |  |  |  | |  |  | |  |  |  |  |  |  |  | | 8. Do you have any renal (kidney) disease? | | | | | | | | | | | Yes | No | |  |  |  |  |  |  |  | |  |  | |  |  |  |  |  |  |  | | 9. Have you ever been on Bisphosphonate medication (either oral or intra venous)? | | | | | | | | | | | Yes | No | |  |  |  |  |  |  |  | |  |  | |  |  |  |  |  |  |  | | 10. Do you have any allergies to medicines (e.g penicillins), substances | | | | | | | | | | | (e.g. latex/rubber) or foods? | | | | | | | | | | | Yes | No | |  |  |  |  |  |  |  | |  |  | |  |  |  |  |  |  |  | |

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| 11. Have you ever had any other serious illnesses? | | | | | | | | | | | | | |
| Yes | | No |  |  |  |  | | |  | |  | |  |
|  | |  |  |  |  |  | | |  | |  | |  |
| 12. Have you ever had treatment that required you to be in hospital? | | | | | | | | | | | | | |
| Yes | | No |  |  |  |  | | |  | |  | |  |
|  | |  |  |  |  |  | | |  | |  | |  |
| 13. Have you had an General Anaesthetic? | | | | | | | | | | | | | |
| Yes | | No |  |  |  |  | | |  | |  | |  |
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| 14. Have you or anyone in the family ever had a bad reaction to General Anaesthetic | | | | | | | | | | | | | |
| or Local Anaesthetic? | | | | | | | | | | | | | |
| Yes | | No |  |  |  |  | | |  | |  | |  |
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| 15. Do you carry a medical warning card? | | | | | | | | | | | | | |
| Yes | | No |  |  |  |  | | |  | |  | |  |
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| 16. Do you regularly drink more than 14 units of alcohol a week? | | | | | | | | | | | | | |
| Yes | | No |  |  |  |  | | |  | |  | |  |
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| 17. Do you smoke or chew (e.g. pan, gutkha or supari) any tobacco products (or did you in the past)? | | | | | | | | | | | | | |
| Yes | | No |  |  |  |  | | |  | |  | |  |
|  | |  |  |  |  |  | | |  | |  | |  |
| 18. Do you use any recreational drugs either now or in the past? | | | | | | | | | | | | | |
| Yes | | No |  |  |  |  | | |  | |  | |  |
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| 19. Please give your approximate height and weight | | | | | | | | | | | | | |
| Height | |  |  |  |  | Weight | | |  | |  | |  |
|  | |  |  |  |  |  | | |  | |  | |  |
| 20. Do you have a physical disability, hearing or visual impairment? | | | | | | | | | | | | | |
| Yes | | No |  |  |  |  | | |  | |  | |  |
|  | |  |  |  |  |  | | |  | |  | |  |
| 21. Do you have a learning difficulty/mental health problem or other special needs? | | | | | | | | | | | | | |
| Yes | | No |  |  |  |  | | |  | |  | |  |
|  | |  |  |  |  |  | | |  | |  | |  |
| 22. Are you currently taking any prescribed medication (tablets, medicines, | | | | | | | | | | | | | |
| ointments/inhalers/contraceptives/HRT)?  **Please list in the box below.** | | | | | | | | | | | | | |
| Yes | | No |  |  |  |  | | |  |  | |  | |
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| **Signed** |  | | | | | | **Date** |  | | | | | |

Berkshire Community Dental Service   
Referral Criteria May 2023

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| **CRITERIA FOR REFERRAL** | **REASONS FOR REFERRALS TO BE RETURNED** |
| 1. Children who have had an episode of pain and/or infection from a baby tooth/teeth and are uncooperative and unable to accept with their dentist unless the child fulfils criteria 3.  *Patients with asymptomatic decay in baby teeth will be rejected.* 2. Children with caries in permanent teeth who are uncooperative and unable to accept treatment. 3. Patients with a learning, physical or severe medical disability which impacts on their dental treatment. 4. Patients with severe mental health problems or dementia which impacts on their dental treatment. 5. Patients with a severe dental phobia whose needs cannot be met by NHS sedation services. *Only those who have been refused by the NHS clinics providing IV sedation or have a learning disability will be considered.* 6. Patients who are unable to leave their home and may require domiciliary treatment. | 1. Does not fulfil criteria. 2. Referral form incomplete. |
| **EXCLUSIONS** |
| 1. Children with asymptomatic decay in baby teeth. 2. Patients referred for IV sedation who do not have a learning disability or have not previously been referred to an NHS IV clinic. 3. Orthodontic Extractions. |

**Please Note:**

* All patients will be assessed against these criteria both on referral and at the consultation appointment and those referrals deemed inappropriate   
  will be discharged.
* Children who fulfil criteria 1 or 2 and do not have a disability will normally be referred to their dentist on completion of the course of treatment.
* Patients with disabilities or requiring domiciliary care may be accepted for continuing care on an individual basis.