Healthcare from the heart of your community

Berkshire Healthcare NHS
NHS Foundation Trust

Berkshire Community Dental Service Referral Form

Any advanced restorative care (including Endodontics/Periodontics/Crown & Bridge) should be referred to the Thames Valley Restorative Care Pathway.

PATIENT DETAILS			
Name:	D.O.B.:	Male/Female	NHS number:
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 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 jobseekers allowance ☐ Universal Credit ☐ Pension credit guarantee credit ☐ Income related employment & support allowance			
Patient mobility status: ☐ Housebound ☐ Wheelchair user ☐ Needs hoist or assistance to transfer to chair			
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 (not secure) ☐ Text			

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 below	

GDP / REFERRER'S DETAILS		
Name of GDP / referrer:	Signature:	Date:
Address (including postcode):		
Practice e-mail address:		Tel no:
I have provided the patient with a copy of the referral form ☐ Yes ***Please note that it is the responsibility of the referring dentist to deal with any dental emergency until we are able to see the patient. Should their dental condition deteriorate the dentist will contact the referral hub.***		
Patient /next of kin signature (Confirming agreement to referral):		Date:

DETAILS OF REFERRAL

Reason for referral – see p4 for guidance on criteria:
Any advanced restorative care (including Endodontics/Periodontics/Crown & Bridge) should be referred to the Thames Valley Restorative Care Pathway.

☐ Uncooperative child

☐ Child likely to require extractions under general anaesthesia

☐ 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*

What treatment is required? (Please give details)	What has been attempted already?

Has the patient had topical Fl treatment recently ☐ Yes, when…….. ☐ No

Has an orthodontic assessment been done: ☐ Yes ☐ No ☐ N/A

An OPG must be included if 6s are of poor prognosis and may need extraction

GA discussion: ☐ Yes ☐ No ☐ N/A

X-rays enclosed: ☐ B/W ☐ P/A ☐ Occlusal ☐ OPG/DPT

If no x-rays provided, please state the reason:

Please return the completed form to:
Referrals, CDS HQ, Skimped Hill Health Centre, Skimped Hill Lane, Bracknell, RG12 1LH
Please ring 07780924990 for any queries about the referral.

Please note that this referral form will be returned to you if it is not complete.

Berkshire Community Dental Service Confidential Medical History Questionnaire

Please answer the health questions below about yourself / child / client.
If you answer **yes** to any questions, **please provide details overleaf**.

Name:	DOB:		
Have you ever had and heart disease/murmur or angina?		Yes	No
Have you ever had heart surgery?		Yes	No
Do you suffer from hypertension (High blood pressure)?		Yes	No
Have you ever suffered from epilepsy/convulsions/fits/faints/blackouts?		Yes	No
Do you suffer from asthma/bronchitis/Tuberculosis (TB)/other chest disease		Yes	No
Do you or any close family members have diabetes?		Yes	No
Do you suffer from any bleeding disorders or bruise easily?		Yes	No
Have you ever suffered from any infectious diseases (including HIV/Hepatitis/Jaundice)?		Yes	No
Do you have any renal (kidney) disease?		Yes	No
Have you ever been on Bisphosphonate medication (either oral or intra venous)?		Yes	No
Do you have any allergies to medicines (e.g penicillins), substances (e.g. latex/rubber) or foods?		Yes	No
Have you ever had any other serious illnesses?		Yes	No
Have you ever had treatment that required you to be in hospital?		Yes	No
Have you had a General Anaesthetic?		Yes	No
Have you or anyone in the family ever had a bad reaction to General Anaesthetic or Local Anaesthetic?		Yes	No
Do you carry a medical warning card?		Yes	No
Do you regularly drink more than 14 units of alcohol a week?		Yes	No
Do you smoke any tobacco products (or did you in the past)?		Yes	No
Do you chew tobacco, pan, use gutkha or supari now or in the past?		Yes	No
Do you use any recreational drugs either now or in the past?		Yes	No
Do you have a physical disability, hearing or visual impairment?		Yes	No
Do you have a learning difficulty/mental health problems or other special needs?		Yes	No
Is there any other information you feel the dentist may need to know about, such as self-prescribed medicines (e.g. aspirin), mobility problems, wheelchair use etc?		Yes	No
Are you currently taking any prescribed medication (tablets, medicines, ointments/inhalers/contraceptives/HRT)?		Yes	No
Please list medications:			
Signed:	**Role/relationship:**	**Date:**	

Berkshire Community Dental Service Referral Criteria May 2016

CRITERIA FOR REFERAL	REASONS FOR REFERRALS TO BE RETURNED TO GDP
1. Children requiring dental treatment who are uncooperative and unable to accept treatment in GDP 2. Children who are likely to require extractions under general anaesthetic 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 6. Patients who are unable to leave their home and may require domiciliary treatment	A. Does not fulfil criteria B. Referral form incomplete C. No referrer and / or patient signature

N.B. All patients will be assessed against these criteria both on referral and at the consultation appointment and those referrals deemed inappropriate will be referred back to the GDP.

- Children who fulfil criteria 1 or 2 and do not have a disability will normally be referred back to their GDP on completion of the course of treatment.
- Patients with disabilities or requiring domiciliary care may be accepted for continuing care on an individual basis.
- Berkshire Community Dental Service is only able to provide intravenous sedation for patients with learning disabilities.
- Berkshire Community Dental Service is unable to provide general anaesthesia for orthodontic extractions unless the treatment plan includes permanent molar teeth.