

**PAEDIATRIC DENTISTRY REFERRAL FORM (CHILDREN 15 YEARS OLD AND YOUNGER)**

<b>Surname:</b>	<b>First Name(s):</b>	<b>Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Prefer not to say
<b>Date of Birth:</b>	<b>NHS Number:</b> (If known)	Is this referral urgent? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Home Address:</b>		<b>PREFERRED INFORMATION</b>
<b>Post Code:</b>	<b>Borough:</b>	<b>GP Name :</b>
<b>Phone:</b>		<b>GP Address:</b>
<b>Mobile contact:</b>		<b>Post Code:</b>
		<b>Borough:</b>
<b>BSL Interpreter Required?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Which language?</b>
<b>Medical History</b> (attach additional information as required)	<b>List all Medication</b> (attach additional information as required)	
<b>Please record here any mobility / transport issues:</b>		
<p><b>Dental History</b></p> <p><b>1. Attendance:</b> Is this child? <input type="checkbox"/> A regular attender <input type="checkbox"/> Occasional, in trouble attender <input type="checkbox"/> Never been before</p> <p><b>2. Dental pain and antibiotics:</b> Over the last week, has the child had toothache? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>3. In the last 3 years have any other children in the family had teeth out because of decay:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>4. Over the last 3 months, has the child had antibiotics for tooth problems?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>5. Toothbrushing and sugar in the diet:</b> Who usually brushes the child's teeth at bedtime? <input type="checkbox"/> The child <input type="checkbox"/> An adult</p> <p><b>6. Preventive advice that has been given, prior to referral:</b> Toothbrushing at bedtime and one other time with fluoride toothpaste with at least 1,000 ppm Fluoride <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>7. Does the child usually have a sweet drink at bedtime?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>8. Dietary advice to reduce free sugars in food and drinks</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p>		
<b>Dental treatment provided, tick ALL relevant boxes:</b>		

- |   |  |
|---|--|
| <input type="checkbox"/> Fluoride varnish applied                     | <input type="checkbox"/> Failed attempt at local anaesthesia |
| <input type="checkbox"/> Fissure sealants applied to permanent molars | <input type="checkbox"/> Behaviour management                |
| <input type="checkbox"/> Temporary fillings                           | <input type="checkbox"/> Any other treatment?                |
| <input type="checkbox"/> No treatment attempted                       | <input type="checkbox"/> Unable to treat (specify reason)    |

**How does the above patient meet the Paediatric Dentistry Referral criteria?**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Dental Caries – Pre co-operative (under 6)  | <input type="checkbox"/> Dental Anomalies – altered tooth structure, number, shape, size, form | <input type="checkbox"/> Surgical management e.g. unerupted teeth/ broken down teeth        |
| <input type="checkbox"/> Dental caries – Over 6 years (expand under history why referral should be accepted) | <input type="checkbox"/> Periodontal (gum) problems  | <input type="checkbox"/> Complex medical problems – expand below                            |
| <input type="checkbox"/> Dental trauma - Primary and permanent. (expand under history)                       | <input type="checkbox"/> Soft Tissue Conditions – mucoceles/ ulcers                            | <input type="checkbox"/> Complex behavioural problems unsuitable for General Practice       |
| <input type="checkbox"/> Opinion about poor quality first permanent molars. No RCT.                          | <input type="checkbox"/> Disorders of tooth eruption and loss                                  | <input type="checkbox"/> Children in the care of social services e.g. Looked after children |
| <input type="checkbox"/> Tooth surface loss – e.g. erosion   |  |   |

**Additional History:**

**What has been explained to parents/guardian?**

- Behaviour management
- Local anaesthesia
- Inhalation sedation
- Intravenous sedation
- General anaesthesia

**Radiographs:**

- Not possible
- Enclosed
- Sent digitally

**Name of Referrer**

**Date of referral**

**Job Title:**

**Organisation:**

**Date Received** (office use)

**Address:**

**Post Code:**

**Phone / Mobile**

**Secure Email:**

**THIS REFERRAL WILL NOT BE ACCEPTED WITHOUT COMPLETION OF ALL SECTIONS. ON COMPLETION PLEASE SEND THE REFERRAL FORM TO RELEVANT CDS PROVIDER**

**REFERRAL / TRIAGE OUTCOME**

**(For completion by CDS provider)**

<b>Date Referral Received:</b>	/ /		
<b>Date of Referral Triage:</b>	/ /		
<b>Triage undertaken by:</b>	<table border="1"> <tr> <td><b>Name</b></td> <td><b>Job Title</b></td> </tr> </table>	<b>Name</b>	<b>Job Title</b>
<b>Name</b>	<b>Job Title</b>		
<b>OUTCOME OF REFERRAL</b>			
<b>ACCEPTED</b>	<input type="checkbox"/>		
Suggested Provider:			
Level I (Training and Education)	<input type="checkbox"/>		
Level II (CDS)	<input type="checkbox"/>		
Level III (Acute Care)	<input type="checkbox"/>		
<b>DECLINED</b>	<input type="checkbox"/>		
Reasons			
1. Insufficient Information with regards to:	<input type="checkbox"/> Patient details		
	<input type="checkbox"/> Reasons for the referral		
2. Radiographs	<input type="checkbox"/> Absent when stated enclosed / electronically transmitted		
3. Inappropriate level of patient complexity to specific unit	<input type="checkbox"/> No evidence that complexity of referral is appropriate to a Level II service		
	<input type="checkbox"/> No evidence that complexity of referral is appropriate to a Level III service (try a Level II service)		