

**Child Dental Health**

**New Patient Referral Form**

***Information for referrer***

**Leave blank for internal use:**

* Completed referral forms should be sent to: **tnu-tr.dentalhospital@nhs.net** **from an NHS email address or via post to Department of Child Dental Health, Newcastle Dental Hospital, Richardson Road, Newcastle-Upon-Tyne, NE2 4AZ.**
* Tier 1 and 2 referrals will only be accepted for undergraduate / junior staff treatment. This information should be given to parents prior to sending a referral. For further clarification on treatment complexity levels please visit[**https://www.england.nhs.uk/wp-content/uploads/2018/04/commissioning-standard-for-dental-specialties-paediatric-dentristry.pdf**](https://www.england.nhs.uk/wp-content/uploads/2018/04/commissioning-standard-for-dental-specialties-paediatric-dentristry.pdf)
* **Please fill in all mandatory fields, incomplete forms with insufficient patient demographics or clinical information will be returned to sender.**
* Adjuncts such as radiographs and clinical photographs should be included where possible. Where these are not possible, a reason should be given.

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| **Section 1. Practice / Referrer Information**  |
| **Date of referral** |  |
| **Referring GDP name** |  | **GDC number** |  |
| **Referring GDP Signature** |  | **NHS.net address (where available)** |  |
| **Practice Referrer Address** |  |
| **Postcode** |  | **Telephone number** |  |

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| **Section 2. Patient Information**  |
| **Title** |  | **First Name** |  | **Surname** |  |
| **Date of Birth** |  | **Age** |  | **Gender** |  |
| **Patient Address** |  |
| **Postcode** |  | **Telephone (mobile)** |  |
| ***NHS/MRN number******(if known)*** |  | **Parent/Guardian e-mail address** |  |
| **General Medical Practitioner Details**  | **Medical History** ***please include relevant details of other health care professionals involved in this child’s care*** |
| **Named Practice**  |  |  |
| **Address** |  |
| **Behavioural/Cognitive/****Communication difficulties** | No [ ]  Yes [ ]  | *If yes, please provide details* |
| **Postcode** |  | **Medications** |  |
| **Telephone No.** |  | **Allergies**  | No Known Allergies [ ] Yes [ ]  Details \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| **Social History**  |  |
| **Social Worker** | No [ ]  Yes [ ]  | **Interpreter required** | No [ ]  Yes [ ]  |
| **Social Worker Details *(if applicable)*** |  | **Language required**  |  |
| **Active Child Protection Plan** | No [ ]  Yes [ ]  | **Are you referring multiple children from the same family?** | No [ ]  Yes [ ]  | **Name(s):** |  |
| **DOB(s):** |  |
| **Child in Care (CIC)? *(previously Looked After Child)*** | No [ ]  Yes [ ]  | **Additional information** |
| *If yes, details of placement*  |  |  |  |

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| **Section 3. Dental History / Reason for Referral**  |
| Regular attender:No [ ]  Yes [ ]  | Last dental visit: | Have radiographs been attempted before? No [ ]  Yes [ ] If yes, were radiographs tolerated? No [ ]  Yes [ ] Have radiographs been enclosed? No [ ]  Yes [ ] *If no, please state reason*  |
| F- Varnish tolerated:No [ ]  Yes [ ]  | Previous GA for dental treatment:No [ ]  Yes [ ]  |
| Seen at NDH before?No [ ]  Yes [ ]  | Seen by CDS before?No [ ]  Yes [ ]  | Details of previous treatment attempted: |  |
| Experience of having treatment under LA: | No [ ]  Yes [ ]  Not attempted [ ]  |
| **Reason For Referral** *please tick all applicable boxes* | **Teeth affected:** **Primary**

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| [ ] E | [ ] D | [ ] C | [ ] B | [ ] A | [ ] A | [ ] B | [ ] C | [ ] D | [ ] E |
| E[ ]  | D[ ]  | C[ ]  | B[ ]  | A[ ]  | A[ ]  | B[ ]  | C[ ]  | D[ ]  | E[ ]  |

 | ***Anticipated Outcome of Referral*** |
| Caries | [ ]  | Opinion and Treatment Plan Only | [ ]  |
| Pain | [ ]  |
| Trauma  | [ ]  |
| Intra Oral Swelling | [ ]  | Referral for undergraduate/ trainee treatment | [ ]  |
| Extra Oral Swelling | [ ]  |
| Enamel/Dentine defects | [ ]  | **Permanent**

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| [ ] 7 | [ ] 6 | [ ] 5 | [ ] 4 | [ ] 3 | [ ] 2 | [ ] 1 | [ ] 1 | [ ] 2 | [ ] 3 | [ ] 4 | [ ] 5 | [ ] 6 | [ ] 7 |
| 7[ ]  | 6[ ]  | 5[ ]  | 4[ ]  | 3[ ]  | 2[ ]  | 1[ ]  | 1[ ]  | 2[ ]  | 3[ ]  | 4[ ]  | 5[ ]  | 6[ ]  | 7[ ]  |

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| Hypodontia | [ ]  |
| Supernumeraries | [ ]  | Specialist / Consultant treatment | [ ]  |
| Soft Tissue Lesion | [ ]  |
| TMD | [ ]  |
| Other  | [ ]  |
| ***History of Presenting Complaint / Further Details of Problem:*** |
| ***Provisional Diagnosis*** |
| Anticipated treatment modality | *Local Anaesthetic* | *Inhalation Sedation* | *Intravenous Sedation* | *General Anaesthetic* |
| [ ]  | [ ]  | [ ]  | [ ]  |
| Urgency | *Urgent* | *Soon* | *Routine* | *Other* |
| [ ]  | [ ]  | [ ]  | [ ]  |

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| **Professional Declaration**  |
| [ ]  | *I confirm that the above referral letter is accurate, to the best of my knowledge* |
| [ ]  | *I confirm that this child has not been referred to any other dental services simultaneously* |
| [ ]  | *I confirm that consent has been sought from Parent/Guardian for referrals for Tier 1 and 2 treatment to be carried out by Undergraduates or Trainee’s* |
| [ ]  | ***\*In the case of referral for treatment under General Anaesthetic,*** *I confirm I have made the Parent/Guardian aware that all teeth of poor prognosis (that are deemed unrestorable) will be removed at the time of General Anaesthetic* |
| **Electronic / Physical Signature****(of referring practitioner)** |  |