A picture containing drawing

Description automatically generated

**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**](mailto: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.

|  |  |  |  |
| --- | --- | --- | --- |
| **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** |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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* |  | |  | | | | | |  | | | | | |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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**   |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | 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**   |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | 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 | | | | | | |
| 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* | | |
|  | |  | |  | |  | | |

|  |  |  |
| --- | --- | --- |
| **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)** | |  |