Referral to the Community Dental Service

*** Mandatory fields**

Northern Lincolnshire and Goole NHS Foundation Trust

PATIENT DETAILS						
Title					Referral Date *	
Forenames*					Surname*	
Gender (✓)	M		F		NHS Number	
Tel:*					DOB*	
Address* Postcode*						
MAIN CARER DETAILS						
Full Name						
Address Postcode						
Tel:						
Is an interpreter required?* (✓)	Yes	No	If yes, please indicate preferred language or requirements			

REFERRER DETAILS			
Name*		Tel (WORK)*	
Work Address*			
Job Title*			
Email Address* (nhs.net if available)			

Previous Dental History (including treatment with local anaesthesia, sedation, general anaesthetic)
Radiographs enclosed: If none please give reason why not:
Current and future arrangements for maintaining oral health and routine dental inspections

DENTAL TREATMENT
What dental treatment does the patient need?* (please state) *For Children please indicate whether General anaesthetic or sedation is expected pathway and all options have been discussed prior to referral.*

REASON FOR REFERRAL* (please see referral criteria) (✓)			
		comments	
Complex Physical disability			
Complex Medical conditions			
Severe Mental Health problems			
Phobia and Anxiety Management			
Learning disability / Autism / ADHD			
Looked after Children			
Children with poor co-operation / anxiety			
Complex Social Problems e.g. homeless / drug dependant / alcohol dependant			
Frail elderly/dementia			
Domiciliary care required			
Bariatric (over 23 stone / 140kg) please state weight		Weight	

Other additional needs			
	Tick		**Comments**
Are there issues with communication?	Yes	No	
Is the service user able to leave home	Yes	No	
Does the service user use a wheelchair?	Yes	No	
Can the service user transfer into a dental chair?	Yes	No	
Does the service use have reduced capacity to make decisions?	Yes	No	

MEDICAL HISTORY including any allergies
Current Medication

REFERRER DECLARATION * (✓)	
☐ I have explained to the patient and/or parent/carer that I am referring them to the Community Dental Service for the reason/ treatment detailed above.	
☐ The patient and/or parent/legal guardian has agreed to this referral.	
REFERRER SIGNATURE*	**DATE***
Post to: Community Dental Services, Referral Department, Cromwell Road Primary Care Centre, Cromwell road, Grimsby, DN31 2BH **Email to: Nlg-tr.communitydentalservice@nhs.net**	