NHSG logo

**Children’s Dentistry Referral Form - excluding Orthodontics**

Send to: Children’s Dental Primary Care Services, NHSG Dental Advice & Referral Centre, Westholme, Queens Road, Aberdeen, AB15 6LS.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **A. Patient’s Personal Details** | | | | |  | Please insert dates in dd/mm/yyyy format | | |
| Date of Referral |  | | | |  | Surname |  | |
|  |  | | | |  |  |  | |
| Gender | Male |  | Female |  |  | Forename |  | |
|  |  | | | |  |  |  | |
| CHI Number |  | | | |  | Date of Birth |  | |
|  |  | | | |  |  |  | |
| Address |  | | | | | | | |
|  |  | | | |  |  | |  |
| Town |  | | | |  | Postcode | |  |
|  |  | | | |  |  | |  |
| Daytime Phone |  | | | |  | Mobile Phone | |  |
|  |  | | | |  |  | |  |
| Home Phone |  | | | |  | e-mail | |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Medical History** *Mark the box and comment where appropriate* | | |  | **Treatment Required** | | | |
| Any Heart complaint/disease |  |  |  |  |  |  |  |
| Epilepsy |  |  |  |  |  |  |  |
| Bronchitis/Asthma |  |  |  |  |  |  |  |
| Hepatitis |  |  |  |  |  |  |  |
| Excessive bleeding |  |  |  |  |  |  |  |
| Any serious illness |  |  |  |  |  |  |  |
| Allergies |  |  |  |  | | | |
| Regular medication |  |  |  | **History of present complaint** | | | |
| Steroids in the last 3 months |  |  |  |  | | | |
| Any history of behavioural problems | |  |  |
| Family history of problems with GA | |  |  |
| Any other comments | | |  |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| Enclosures  e.g. radiographs  Additional Information |  | **Reason for referral** |  |
|  | 1.Anxiety/phobia |  |
|  | 2.Special Needs |  |
|  | 3.Complex treatment |  |
|  | 4.Specialist opinion |  |
|  |  |  |
|  |  |  |

Registered patient

Occasional patient

Name of Parent/ Legal Guardian/ Carer

**Keep a copy of this form for your records.**

**REFERRING PRACTITIONER**

|  |  |  |  |
| --- | --- | --- | --- |
| GDP STAMP/DETAILS |  | Name, address and telephone of patient’s GP | |
|  |  | Name: Dr | |
|  | Address: | |
|  | 🕿: | |
| **Administrative Information for the Referral Service** *(Do not write in the box below)* | | | |