

**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       |  |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| Enclosurese.g. radiographsAdditional 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)* |