Normal NHS Patient Charges Apply

**Primary Care Dental Services Referral Form – Special Care Dentistry**

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

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **A. Patient’s Personal Details** | | | | |  |  | | | | |  | |
| Referral date |  | | | |  | Surname | | | | |  | |
|  |  | | | |  |  | | | | |  | |
| Gender | Male |  | Female |  |  | Forename | | | | |  | |
|  |  | | | |  |  | | | | |  | |
| CHI number |  | | | |  | Date of birth | | | | |  | |
|  |  | | | |  |  | | | | |  | |
| Address |  | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| Town |  | | | | | |  | | | Postcode | |  |
|  |  | | | | | |  | | |  | |  |
| Daytime Phone |  | | | | | |  | | | Mobile Phone | |  |
|  |  | | | | | |  | | |  | |  |
| Home Phone |  | | | | | |  | | | e-mail | |  |
|  |  | | | | | |  | | |  | |  |
| If your patient needs to communicate in a mode or language other than English please specify: | | | | | | |  | |  | | | |
| Please state whether an accompanying person can translate or if an interpreter will be needed: | | | | | | |  | |  | | | |
|  | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| **Name of contact person**: | | | | | | | | **Relationship / status** e.g. relative / key worker / social worker etc: | | | | |
| Address | | | | | | | | | | | | |
| Tel: | | | | | | | | | | | | |
| Please indicate if: Domiciliary  Bariatric | | | | | | | | | | | | |

**Reason for Referral**

|  |
| --- |
| **Clinical Reason for Referral** |
| **Expectation of Referral Service** |
| **Medical history** Please listall current medications taken and any specialist medical clinics attended: |

**Special Care Dentistry Referral Form** Page 2

|  |  |  |  |
| --- | --- | --- | --- |
| Please re-enter patient’s name |  | & DoB |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Further Information | | | Please tick | | | |  | | | | | | |  |  | | | | |  |
| Access | | |  | | | | Medical complications | | | | | | |  | Anxiety / phobia | | | | |  |
|  | | | | | | | | | | | | | | | | | | | | |
| Learning disability | |  | | | | | Mental Illness | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| **Does the person go out at all?** | | | | | | Yes | |  | | No |  | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| **Living arrangements:** | | | Alone | | | |  | With family | | | | | | |  | | In care | | |  |
|  | | | | | | | | | | | | | | | | | | | | |
| **Mobility:** | Able to weight bare | | |  | Needs walking aid | | | | | |  | | Wheelchair user | | | | |  | Bedbound |  |
|  | | | | | | | | | | | | | | | | | | | | |
| **Does patient have capacity for consent** | | | | | | | | | Yes | | |  | | No | |  | | | | |
| If no please enter details of Welfare Guardian  **Name**       **Contact Number** | | | | | | | | | | | | | | | | | | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | | | | | |
| **Help that you can provide** | | | | | |
| *Please include details of dental care that you are able to provide e.g. prevention, as well as your referral request* | | | | | |
|  | | | | | |
|  | | | | | |
| **Enclosures** (e.g. radiographs, study models, photographs) | | | | | |
| Would you like these returned? | Yes |  |  | No |  |
|  | | | | | |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Is the patient registered at your practice? | | Yes |  | No |  |  | | |
|  | | | | | | Please mark box to confirm | | |
| I confirm this patient referral comes within the current referral guidelines issued by NHS Grampian Dental Services | | | | | | | |  |
|  | | | | | | | | |
| Print Name of Referring Clinician |  | | | | | | | |
|  | | | | | | | | |
| Signed (Clinician) |  | | | | Date | |  | |

**REFERRING PRACTITIONER**

|  |  |
| --- | --- |
| GDP STAMP/DETAILS | GMP STAMP/DETAILS |
|  |  |

|  |
| --- |
| **Administrative Information for the Referral Service** *(Do not write in the box below)* |
|  |