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)* |
|  |