Hertfordshire Community NHS
NHS Trust

SPECIAL CARE DENTAL SERVICE

Patient Referral Form – for use by ***Health Care Workers***

Patients of any age with special needs who meet the service acceptance criteria will be considered. All sections of this form must be fully completed to avoid unnecessary delays and incomplete forms will be returned. An electronic version is available on request.

Once completed please send this form to :
Clinical Director, Special Care Dental Service, The Red House, Harpenden Memorial Hospital, Carlton Road, Harpenden, AL5 4TA Tel: 01582 714195/714190 Fax: 01582 713657

SECTION 1 – Acceptance Criteria

The patient being referred is a Hertfordshire resident who : *please tick*

- ☐ Is a wheelchair user unable to transfer to the dental chair without the use of a hoist
- ☐ Has a diagnosed moderate/severe learning disability who cannot be managed in General Dental Practice
- ☐ Has a diagnosed moderate/severe mental health problem who cannot be managed in General Dental Practice
- ☐ Has a complex medical condition not manageable in General Dental Practice

Please give details :

SECTION 2 – Patient details

Title	First name	Surname
Date of Birth	NHS number	
Address		Post Code
Daytime Tel No.	Mobile Tel No.	
Does this patient need an interpreter ?	YES	NO
If 'Yes' which language would be required :		

SECTION 3 – Treatment detail

Please give details of treatment requested

Does this patient have any of their own teeth ?	*Yes*	*No*

Is this patient in unmanageable pain ?	*Yes*		*No*	
Has the patient ever displayed any aggressive behaviour ?	*Yes*		*No*	
If yes, please give details e.g. known triggers				
Has the patient seen their own General Dental Practitioner within the last year ?	*Yes*		*No*	
If yes, please give name of dentist(s) and address/telephone number				

REFERRING HEALTH CARE WORKER'S NAME & CONTACT DETAILS

Name
(Please print)

Address

Job Title Tel. No.

Signature Date

PATIENT/PARENT/LEGAL GUARDIAN *Please delete as appropriate:*

1. I would be happy to accept an appointment at the clinic with the shortest waiting time

2. I would prefer to wait for an appointment at the clinic closest to my home

I confirm that I understand and agree with the reasons for this referral.

Signature _____ Date

Relationship to patient _____

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TRIAGE OUTCOME *(for SCDS use)*

Date

Patient accepted for treatment	
Patient does not meet any of the criteria for this service	
Consider redirection of referral to MOS service (from PCT list)	
Consider redirection to a sedation practice (from PCT list)	
Incomplete referral form	
Comments	