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.

| <u> </u> | r, Special Care Dental Service, T Harpenden, AL5 4TA Tel: 0 | ed please send this The Red House, H 11582 714195/714 | arnenden Memorial Ho | spital, Carlton Road, 7 |
|--|---|--|--|---|
| SECTION 1 - Acce | ptance Criteria | | | |
| • Is a whoist • Has a of Genera • Has a manage • Has a of | eferred is a Hertfordshire neelchair user unable to diagnosed moderate/sevel Dental Practice diagnosed moderate/seed in General Dental Practice complex medical condition give details: | transfer to the ere learning di evere mental ctice | e dental chair with sability who cannot health problem | ot be managed in who cannot be |
| SECTION 2 – Patie | nt details | er kananda Hukuluka asal Pinohi Birmeh zamak zaka adak da sahik da s | acant as All Moneyers (All ST Publishers and SELECTION STATE And American Republican planning | Sentron (Camping House, and reading out (City and distribute Annual London and Senter, Annual London Sentingue |
| Title | First name | A CONTROL OF CONTROL O | Surname | Or Valent van Cipe aan sjurg vegt dat sp. Seesson en ij vand in en gijde fûndeld die man, mot omte gehalft wederde, waarook aan de saads |
| Date of Birth NHS numb | | er | | |
| Address | | | | Post Code |
| Daytime Tel No. | | Mobile Tel No. | | N - MANAGARAN - W - MANAGARAN |
| Does this patient need an interpreter ? If 'Yes' which language would be required : | | YES | | NO |
| SECTION 3 — Treati | ment detail | de Valamicha Chhiline at I / Arbumanh agh eann-ci Amain 9 a (C) Agus ha gaar | MANA Kalamentelijä sejä maikisterinäälejän kyvinnyyysen (SANY) sienderinäänelerysänsäytöjä | dissemblishmisismalis (Edelma), a formbassionisismalishmisisman Abbumatikan san berempira debenad |
| Please give details c | f treatment requested | aaken da ak kalemente aaken soolooteleen een en en soon aakaen. | Smither the State CCC serve s ACCS series (State Accessed the State Accessed the | |
| Does this patient hav | e any of their own teeth | itti astolotuvas erotoin jarotastoi isuva sa esimennisi Milymmet uutuvan kontrolot erotoonisi kapaosamuu | nterestrikansk krististopanistist (marata krististopanististopanististopanististopanististopanististopanistist NYTOTATATATATATATATATATATATATATATATATATAT | омення выполня выполня В выполня выполн |

| Is this patient in unmanageable pain? | Yes | No | | | |
|--|--|--|--|--|--|
| Has the patient ever displayed any aggressive behav | iour? Yes | No | | | |
| If yes, please give details e.g. known triggers | | | | | |
| Has the patient seen their own General Dental Practivithin the last year? | Yes | No | | | |
| If yes, please give name of dentist(s) and address/tel | ephone number | | | | |
| REFERRING HEALTH CARE WORKER'S NAME & Name | CONTACT DETAILS | THE THE PARTY OF T | | | |
| (Please print) | | | | | |
| Address | | | | | |
| | | | | | |
| Job Title | Tel. No. | | | | |
| Signature | Date | | | | |
| PATIENT/PARENT/LEGAL GUARDIAN | Please delete as | s appropriate: | | | |
| 1. I would be happy to accept an appointment at the cli | nic with the shortest waiting time | | | | |
| 2. I would prefer to wait for an appointment at the clinic | closest to my home | | | | |
| confirm that I understand and agree with the rea | isons for this referral. | | | | |
| Signature | Date | | | | |
| Relationship to patient | | | | | |
| And the control of th | | PERSONAL PROPERTY CONTRACTOR CONT | | | |
| Once completed please Clinical Director, Special Ca The Red House, Harpenden Memorial Hospi Tel: 01582 714195/714190 F | are Dental Service tal, Carlton Road, Harpendei | n, AL5 4TA | | | |
| TRIAGE OUTCOME (for SCDS use) | | | | | |
| Patient accepted for treatment | Date | WWW. | | | |
| Patient does not meet any of the criteria for this | | | | | |
| | | | | | |
| Incomplete referral form | HT OT 115U | | | | |
| Comments | | <u></u> | | | |
| Consider redirection of referral to MOS service Consider redirection to a sedation practice (fror Incomplete referral form | (from PCT list) | | | | |