South Eastern Health and Social Care Trust

Community Dental Service Referral Form

E-mail: CDSReferrals@setrust.hscni.net **(each patient in a separate email please)**

A. Patient Details

Date of referral:		Patient's date of birth:	
Patient's surname:			Gender:
Patient's forename:			
Patient's Health & Care number: ***MANDATORY***			
Contact address:			
Town or city:		Postcode:	
Daytime/mobile phone:		Home phone:	
Does your patient need to communicate in a language or mode other than English? If yes, please specify:		Yes ☐ No ☐	
Does your patient need to use a stretcher/wheelchair? Yes ☐ No ☐		Stretcher ☐ Wheelchair ☐	
Does your patient have any additional needs? Yes ☐ No ☐		Please specify additional needs:	
GP Name:			
GP Practice name and address:			
Has the patient attended the Community Dental Service before?			Yes ☐ No ☐

B. Referrer Details

Referrer:	GDP ☐	GMP ☐	Other ☐
If 'other' please specify:			
Name of referrer:			
Referrer address:			
E-mail address:			
Telephone number:			

C. Referral Details

Which discipline should see the patient? (please tick ONE only)		
Elderly Care ☐	Paediatric dentistry ☐	Special Care Dentistry ☐
Paediatric GA extraction Service	***Please complete separate form***	
Other (specify): ☐	Click here to enter text.	

Reason for referral and relevant dental history

Relevant medical history:	Medications:

URGENT Yes ☐ No ☐ *(if yes please tick one or more of the following):*	Reason for urgent referral:	
	Suspected cancer ☐	Pain for 48 Hours ☐
	Swelling ☐	Trauma ☐
	Other (specify): ☐	Click here to enter text.

I confirm that this patient referral meets the relevant acceptance criteria as stated in the current referral guidelines. ☐

Available at: https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/Review%20of%20CDS%20-%20Scope%20of%20Service%20Specification.pdf

D. Radiographs and supporting documentation

Format of radiographs included *MANDATORY* *(include any relevant radiographs taken in the past 12 months)*
Images must be labelled with patient identifiers (Name, Date and R/L) or the referral will be rejected

Digital radiographs (in digital format only) ☐	Traditional/acetate radiographs ☐
Please email this form and attach digital radiographs to CDSReferrals@setrust.hscni.net	Please print a copy of this form and send with radiographs to the address overleaf.

NB Printed digital radiographs are not of sufficient diagnostic quality and cannot be accepted.

Additional supporting documentation attached ☐ Please specify: Click here to enter text.

Please email this form and attachments to CDSReferrals@setrust.hscni.net

PLEASE ENSURE THIS FORM IS COMPLETED CORRECTLY AND ANY RADIOGRAPHS AVAILABLE ARE INCLUDED

E. Patient Medical History

1. Does the patient have any of the following diagnoses? Please tick as required:

Heart problems	☐	Bleeding disorders	☐
Chest problems e.g. Asthma	☐	Kidney problems	☐
Allergies	☐	Medically fit and well	☐
Diabetes	☐	Epilepsy	☐

Please use this space to provide details:

2. Is the patient under the care a doctor, medical specialist or hospital? Yes ☐ **No** ☐

If Yes, please provide details:

3. Is the patient taking any medication /inhalers? Yes ☐ **No** ☐

If Yes, please provide details:

Please note:

The Community Dental Service reserves the right to refer patients back to their General Dental Practitioner if they do not fit any of the criteria the service is commissioned to provide, or if the form is not legible or completed fully.

Please complete:

Dentist's Signature:_____ Print Dentist's Name: _____

This form can also be printed and sent to your nearest Community Dental Clinic