

## **Community Dental Service Referral Form**

E-mail: <a href="mailto:CDSReferrals@setrust.hscni.net">CDSReferrals@setrust.hscni.net</a> (each patient in a separate email please)

## A. Patient Details

A. Patient Details						
Date of referral:			Patient's date	of birth:		
Patient's surname:					Condon	
Patient's forename:					Gender:	
Patient's Health & Care						
number: *MANDATORY*						
Contact address:						
Town or city:			Postcode:			
Daytime/mobile phone:			Home phone:			
Does your patient need to language or mode other t If yes, please specify:		a	Yes		No	
Does your patient need to		$\Box$	Stretcher	☐ Wh	eelchair	
use a stretcher/wheelchair?  Ves INO I Stretcher Wheelchair L  Does your patient have any Please specify additional needs:						
additional needs?	Yes L No		,			
GP Name:						
GP Practice name and address:						
Has the patient attended the Community Dental Service before?  Yes No					No 🗌	
<b>B.</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 pa	itient? (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:						
	Dancas facilities							
	Reason for urgent referral:							
LIDCENT								
URGENT	Suspected cance	r $\square$	Pain for 48 Hours					
Yes No	Suspected cance	r 🗆	Pain for 48 Hours					
Yes No (if yes please tick one or more of	Suspected cance Swelling	r	Pain for 48 Hours  Trauma					
Yes No	·	r						
Yes No (if yes please tick one or more of the following):	Swelling Other (specify):		Trauma  Click here to enter text.					
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## **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	e 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 me If Yes, please provide details:	dication /inhalers?	Yes No				
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 Der	ntist's Name:	· · · · · · · · · · · · · · · · · · ·			

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