South Eastern Health and Social Care Trust

Referral for Dental Assessment - Residential Clients

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

Patient's Name:		Date of Referral:
Patient's Health & Care Number:		DoB:
Address:		Floor/Room Number if applicable:
Name and address of GMP:		
Name and contact details of Contact person (e.g. Relative, Key worker, SW)		

Is the patient registered with a High Street Dentist?

☐ Yes - do not continue with this referral – contact the High Street Dentist

☐ No

If not, what is the reason the patient is not registered:

☐ No attempts made to register

☐ Attempted but unable to find a General Dentist to register with:

☐ Other ……..

Eligibility for Domiciliary care

Can the patient attend appointments/social events? e.g. doctors/hospital, shopping, hairdresser

☐ Yes

☐ No

If they attend any appointments how do they get there?

☐ Ambulance

☐ Taxi

☐ Car

☐ Other ……

Who will accompany the patient? ……

Mobility

☐ Walks unaided

☐ Needs Assistance

☐ Wheelchair user

☐ Confined to home/bed

Incomplete or insufficient information may result in the referral being rejected

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Reason for Referral - please include as much detail as possible/attach clinical pictures if applicable

☐ **Pain**

Pain Type: ☐ Constant ☐ Comes and goes
Taking any pain relief? ☐ Yes ☐ No
If yes, what: ……..
Is pain manageable with pain relief? ☐ Yes ☐ No
Does pain keep awake at night? ☐ Yes ☐ No
Can the resident eat or drink? ☐ Yes ☐ No

☐ **Swelling**

Where is the swelling? ……..
Swelling severity ☐ None ☐ Mild (localized to gums) ☐ Moderate ☐ Severe (face/eye/neck involved)

☐ **Bleeding**

Cause of bleeding: ☐ Injury ☐ Unknown ☐ Tooth-brushing ☐ Other ……
Bleeding: ☐ Stopped with pressure ☐ Ongoing despite pressure ☐ N/A

☐ **Lost filling or crown**

Is this affecting function (eating/speaking)? ☐ Yes ☐ No ……
Discomfort level: ☐ No pain ☐ Mild ☐ Severe (please complete Pain section above)

☐ **Broken denture or broken tooth** -

Is this affecting function (eating/speaking)? ☐ Yes ☐ No ……
Discomfort level: ☐ No pain ☐ Mild ☐ Severe (please complete Pain section above)

☐ **Soft tissue lesion of mouth e.g. Ulcer**

Where is the lesion? ……
What size is lesion? ……
What colour is it? ☐ White ☐ Red ☐ Mixed Red/White ☐ Purple ☐ Other ……
How long has it been there for? ……

Other information:

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Does the Client have any significant medical issues we should be aware of?

If yes, details: _____

Allergies: _____

Does the Client have:			**Please give details**
Communication difficulties	Yes	No	……
Dementia/confusion	Yes	No	……
Swallowing problems	Yes	No	……
Oral nutritional supplements	Yes	No	……
History of alcohol excess	Yes	No	……
Smoking history	Yes	No	……
Any allergies	Yes	No	……

Referrer Details:	Name	
	Address	
	Telephone	
	Relationship to client	

Currently only URGENT domiciliary visits are being prioritised.

Waiting times for ROUTINE Domiciliary visits will have significant waits

Access to General Dentist or referral to Community Dental Clinics will be quicker.

N.B. Routine provision of dentures – IS NOT CURRENTLY AVAILABLE but

URGENT denture cases will be assessed individually

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