Periodontal Referral Pro-forma

Belfast Health and Social Care Trust

All referrals are reviewed by a Dental Consultant. Periodontal dentistry referral criteria can be viewed on http://www.belfasttrust.hscni.net/services/DentalServices.htm. Please complete pages 1 & 2 of the referral. Inappropriate referrals will be returned with specific reason(s) outlined.

PATIENT DETAILS

Patient Name: _____ Gender: _____

Address: _____ Date of Birth _____

_____ Home Tel No:_____

Post Code _____ Mobile No:_____

H&C No. _____

Is an interpreter required Yes No Language_____

REFERRER DETAILS

Name of referring Practitioner/ Clinic: _____

Address:_____ Date of Referral: _____

_____ Post code: _____

Contact Tel No:_____ email:_____

For SoD use only:

Referral Source:

GDP ☐ CDS ☐

Dental Specialist ☐

Medical Specialist ☐

Referral Not Accepted ☐

Response letter completed ☐

Date referral received by
New Patient Appointments Office

GENERAL MEDICAL PRACTITIONER DETAILS

General Medical Practitioner: _____

Address: _____

_____

Post Code:_____ Contact Tel No:_____

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Patients Name _____ **H&C No.**

CLINICAL REASON(S) FOR REFERRAL. Please provide a provisional diagnosis.

BPE Score:

PREVIOUS TREATMENT HISTORY
For patients with gingivitis or periodontitis a previous course of non-surgical periodontal treatment should have been provided. Please provide full details of all previous treatment, including clinical details of the response to treatment provided.

Relevant medical history and current medications:

Is the patient a smoker or has the patient smoked in the past 6/12? **Y** ☐ **N** ☐

_____

Wheel-chair User: **Y** ☐ **N** ☐ Ambulance required: **Y** ☐ **N** ☐

Type _____

I confirm that this patient's referral meets the Restorative Dentistry referral criteria issued by the School of Dentistry, Belfast HSC Trust.

Signature of referring practitioner:_____ Print name:_____